The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
Elizabeth Childs, MD, Commissioner

DRAFT

FISCAL YEAR 2004
ADULT AND CHILD/ADOLESCENT
IMPLEMENTATION REPORT

December 2004

TABLE OF CONTENTS

FISCAL YEAR 2004 IMPLEMENTATION REPORT

"The mission of the Department of Mental Health is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective and efficient and culturally competent services that promotes client rights, responsibilities, rehabilitation and recovery."

FISCAL YEAR 2004 IN REVIEW

As described in last year's Implementation Report and this year's State Mental Health Plan, the Department of Mental Health (DMH) is part of the Health cluster within the Executive Office of Health and Human Services (EOHHS). The cluster also includes the Department of Public Health (DPH), Medicaid (acute services only) and the Division of Health Care Finance and Policy. In a critical move, the Medicaid acute behavioral health programs (mental health and substance abuse) have been aligned with mental health services under the DMH umbrella and DMH has begun to solidify its role as the mental health authority and "go-to" agency for all questions concerning mental health from the other EOHHS agencies. Strong leadership from EOHHS and continued support and advocacy from the broader mental health community resulted in a more positive budget for DMH for SFY'05.

Reorganization and a stabilized budget portend well for a more integrated approach to caring for people with co-occurring mental illness and substance abuse disorders and for coordinating mental health care with primary health care. The new DMH Commissioner, Elizabeth Childs, MD, assembled her management team with an eye toward integrating the acute behavioral health programs into DMH, improving accountability and quality management, and revitalizing data collection and analysis.

Massachusetts was able to hold certain program areas "harmless" in the face of the previous two years' budget cuts, such as child and adolescent services, homeless services, clubhouses, adult residential services and Program for Assertive Community Treatment (PACT) teams. However, it took creativity to maintain services at acceptable levels and move the system forward in such challenging times.

One of the most notable achievements this year was the landmark Inpatient Study Report that DMH produced for the legislature. This report articulated the vision of a comprehensive system of care that expands community-based services while consolidating two antiquated inpatient facilities (both were built before 1900). The report, which was endorsed by EOHHS and received positively by the legislature, laid the foundation for outside language in the SFY'05 budget that established a special commission to undertake a feasibility study for building a new, state-of-the-art inpatient facility in central Massachusetts. Ironically, one of these two hospitals, Westborough State Hospital, was surveyed by the Centers for Medicare and Medicaid during the year and received a glowing report on the *quality* of the work being done there. The surveyors spoke of the facility in superlatives and reported that it was unique in their experience to find a facility that required no citations or corrective actions. The goal of DMH is to maintain the quality of the work but to improve the quality of the environment in which the work (care of patients) takes place.

The Commissioner also issued a Restraint and Seclusion Philosophy Statement during the year that formalized the prevention model being utilized statewide in the child and adolescent inpatient system and signaled her commitment to extend this philosophy, and the training necessary to implement it, to the adult state-operated inpatient facilities.

As a result of budget adjustments, DMH was forced to make significant changes to the *three-year* Plan (2002-2004) it originally submitted in September 2001 as part of its 2002 Block Grant application. Changes affected goals for SFY'02, '03 and '04. This Implementation Report is based on the amended Plan for SFY'04. Despite budget

reductions, DMH has succeeded largely in maintaining its community-based service system.

To the extent possible, DMH has selected indicators that may be measured using automated data sources to provide interested stakeholders with a "report card" displaying accomplishments, trends and gaps. Some of the items DMH has chosen to measure are: case management, residential services, employment, access, level of functioning, participation in treatment planning, community tenure, smoking reduction, and options for people with mental illness who are homeless.

During SFY'04, DMH continued to implement its Mental Health Information System (MHIS). As described in previous plans, DMH has customized a commercially available software system to fit its unique clinical and business environments. The system is being implemented in three phases: Phase I involves admission, administrative and billing procedures in DMH inpatient facilities; Phase II focuses on DMH case management and community services; Phase III involves development of an electronic medical record in the DMH facilities. When fully implemented, the MHIS will enable DMH to track services either directly provided or funded by DMH for continuing care clients and to retrieve inpatient clinical information. One of the consequences of implementing Phase II has been the concomitant need to ensure that all client information transferred to the new system is current. This has entailed the "scrubbing" of data and removing the names of clients who are no longer active but had been retained in the system. As a result, comparisons with previous years' data are not always possible, and the goals that DMH set based upon those numbers have had to be adjusted. It also means that in some instances, we are still getting data from more than one source. This should be remedied in next year's report. Phase I has been implemented in all DMH facilities. Phase II, the community system, was operating in five of the six areas by the end of the fiscal year. Phase III is "live" in all three state hospitals and two CMHCs (as of August) and will be rolled out to the other CMHCs by the spring of 2005.

As an adjunct to the development of MHIS, and in order to meet the uniform data reporting requirements of the block grant, DMH has received a new, three-year Data Infrastructure Grant from CMHS (2005-2007). DMH plans to use the grant in several ways. First, an interface with MHIS has been created to provide the information in the reporting format required by CMHS. Second, an appropriate data gathering system is being created to fill in the few blanks that remain between the CMHS requirements and MHIS. Finally, and principally, DMH will use the grant to develop and implement a statewide consumer satisfaction survey. This is a project that has not been undertaken on a statewide basis before, although DMH has contracted previously with Consumer Quality Initiatives, Inc., a consumer –run organization, to conduct targeted consumer surveys (i.e., inpatient, residential, case management) for several years.

DMH continues to maintain its Internet website at www.state.ma.us/dmh. DMH responded to more than *400* requests for help or information received through this website in SFY'04. The site allows DMH to provide information about its services, employment opportunities, policies, regulations, etc. to a local, state and worldwide audience and complements the internal Intranet site that DMH has operated for its own employees for four years. EOHHS has designed and is implementing a coordinated, virtual gateway for all its constituent agencies and for all consumer, provider, researcher and government inquiries. As of this writing, DMH has moved the content of its Internet website into this EOHHS portal.

DMH has continued a host of other initiatives, including various collaborative efforts to promote interagency cooperation and systems integration for shared populations. One long-term goal has been to improve the interface between DMH clients and their primary care providers. DMH's commitment to decrease fragmentation in the service delivery system for children and adolescents has been adopted as a priority by EOHHS. Specific child and adolescent initiatives focused on service integration include the EOHHS mental health enhancement project, led by DMH, that is analyzing the mental health needs of children receiving services from the Departments of Social Services (DSS), Youth Services and Mental Retardation and developing plans to meet those needs. Ongoing interagency direct service projects include: the statewide DMH/DSS Collaborative Assessment Program for children at risk of out-of-home placement; "Worcester Communities of Care," a services demonstration project funded by the Center for Mental Health Services; the Mental Health Service Program for Youth, administered by Medicaid; and the Medicaid Coordinated Family-Focused Care pilot program, also designed to prevent out-of-home placement through provision of wraparound services.

Significant Activities in Fiscal Year 2004

Shifting Inpatient Focus to Community-based Care

As previously reported, DMH closed Medfield State Hospital, as well as a 20-bed unit at Worcester State Hospital and a 36-bed unit at Tewksbury Hospital (a DPH/DMH facility), in SFY'03, reducing adult inpatient capacity from 1,127 to 948 (900 continuing care, 48 acute beds). A significant portion of the savings (in operating funds) derived from closing Medfield was used to expand community services. Specifically, the funds were used to develop *255* community placements for patients residing in a number of DMH facilities, to increase the number of DMH-funded PACT teams from five to 13, and to create two new adult inpatient units in another DMH hospital for Medfield patients needing ongoing inpatient care.

However, cuts to services at some community sites were necessary to accommodate anticipated SFY'04 budget reductions. To prevent further cuts in community services, DMH proposed closing Worcester State Hospital in SFY'04. The legislature rejected this option in its SFY'04 budget but mandated a study commission to examine the implications in further detail. The Inpatient Study Report examined trends in the use of acute care general and private psychiatric hospitals, trends in admissions, census, discharges and lengths of stay in DMH facilities, trends in civil versus forensic admissions to DMH hospitals, peer state comparisons, and number of discharge-ready patients at DMH facilities. Next, the report calculated how savings derived from the hospital closings could be used to place the *268* discharge-ready patients into appropriate community settings and also made a recommendation regarding the optimal number of continuing care hospital beds.

Restraint and Seclusion Reduction Initiative

Since the beginning of 2001, the DMH Licensing and Child/Adolescent divisions have been actively promoting strength-based interventions, through the Department's licensing and contracting authority, to reduce the utilization of seclusion and restraint in child and adolescent inpatient facilities and intensive residential treatment programs. DMH collects statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient facilities (adults, children and adolescents) and intensive

residential treatment programs (children and adolescents). Review of restraint data from each facility and program and a discussion of prevention, early intervention and pro-active planning efforts are a focus of each two-year licensing visit and the more frequent contract monitoring visits and consultations.

A combination of conferences, grand rounds, clinical consultation and technical assistance on state-of-the-art practices produced impressive rates of reduction in the child and adolescent units and programs, the particular focus of these activities, as reported last year. The DMH Commissioner's philosophy statement codifies the Department's commitment to end these practices. However, due to changes in the Centers for Medicare and Medicaid's definitions of restraint, SFY'04 data are not comparable to previous years' data. It will take a while to educate all the providers about the new rules in order for them to continue to be able to report data in a uniform way.

A similar initiative, supported by SAMHSA, was launched in 2003 by the National Technical Assistance Center, the technical assistance arm of the National Association of State Mental Health Program Directors, for state hospitals (adult and child) nationwide. Two (adult) state hospitals in Massachusetts participated in this initiative, as did DMH licensing and child/adolescent staff. The initiative will be expanded to all of the DMH state hospitals.

Anti-Stigma Campaign

Massachusetts was one of eight pilot states selected by SAMHSA to pilot a national anti-stigma campaign called the "Elimination of Barriers Initiative (EBI)." This campaign coincided with the release of the President's New Freedom Commission on Mental Health Final Report, "*Achieving the Promise: Transforming Mental Health Care in America*," and aims to address stigma in targeted segments of the population. It builds on an existing DMH campaign, called "*Changing Minds*," which was developed when a statewide survey revealed that stigma would prevent most people from seeking treatment for a mental illness. Its goal was to educate the public about mental illness. For EBI, DMH chose to focus its efforts on middle and high school age students and school administrators, groups that were identified in national focus groups as high profile target audiences. In July 2003, the DMH Commissioner made a presentation about EBI to the Massachusetts Association of Secondary School Administrators. In the spring of 2004, DMH began distributing television, radio and print public service announcements to media outlets across the state and provided the first training on the EBI curriculum to staff at Jeremiah Burke High School in Boston. Three other high schools have asked to participate as pilot sites for the training.

Psychiatric Residency and Psychology Internship Training Program

This long-standing training program was re-procured in 2003 to assure public sector clinical training experience for future mental health professionals. Through this five-year contract, DMH provides support for adult, child and forensic psychiatry residents, and psychology interns and fellows in eight accredited hospital training programs affiliated with the Harvard, Boston University and University of Massachusetts medical schools. DMH established curriculum requirements for the trainees in such areas as cultural competence, homelessness and mental illness, co-occurring mental illness and substance abuse disorders, programs for assertive community treatment, psychosocial rehabilitation, family involvement, and reducing seclusion and restraint. The new contract requires each program to provide its trainees with at least one clinical rotation at

a DMH-affiliated site/program, providing a benefit for both the trainees and for DMH. DMH also encourages the training programs to incorporate the use of consumers as teachers. In SFY'04, Consumer Quality Initiatives, Inc., a consumer-run organization, met with the training program directors and DMH to design a client satisfaction survey to be used with each of the training programs.

Cultural Competency

DMH continues to support statewide and Area-based activities that involve outreach to cultural communities. The DMH Office of Multicultural Affairs directs a statewide Cultural Competence Action Team as well as a professional Multicultural Advisory Committee, and each Area has a multicultural committee and/or diversity team. The SFY'04 objectives in the three-year Cultural Competency Action Plan were largely achieved and are described in this report.

The Implementation Report

DMH continues to use the CMHS format with five criteria - **I**, **II**, **IV** and **V** for adults and children, and **III** for children only. There are performance indicators for each criterion. For ease of reading, Performance Tables are included with each indicator as well as at the end of each section.

DMH is submitting Basic and Developmental Data Tables (Uniform Data Infrastructure Grant) as part of its SFY'04 Implementation Report. The tables are being submitted electronically; the other required forms may be found in the Appendix. Completing the tables and aligning them with other block grant data continued to present a challenge, as DMH continued its conversion of the existing client tracking system to a new Mental Health Information System. At the end of the fiscal year, only five of the six DMH areas had completed the conversion. In addition, as each conversion has taken place, data have been "scrubbed." The goal is laudable; to include only active cases and/or eligible clients in the new system. Getting there, however, means occasional inconsistent (non-uniform) reports when history is "revised" to accommodate newer and more accurate information. It also means that goals set by DMH in the Plan, based on old data, may not have been appropriate. We are working hard to remedy this for future reporting. Secondly, as noted in this report, DMH uses an age cohort for children and adolescents that is different from the federal definition and the Uniform Data Tables. In Massachusetts, children and adolescents include those from birth through 18, whereas the federal cohort includes children and adolescents birth through 17. This difference is footnoted in the Data Tables and in the Implementation Report.

CRITERION I: ADULT PERFORMANCE INDICATORS

Comprehensive Community-Based Mental Health Service System

Goal I/1 A: Ensure that all DMH clients receive coordinated and integrated services.

Population: **Adults with serious mental illness**

Objective I/1 A: Maintain the number of adults receiving case management services.

Brief Name: *Case Management*

Indicator: the number of adults receiving case management in each fiscal year

Measure: # of adults receiving case management each fiscal year
# of adults receiving case management at baseline (SFY'01)

Year 3: Maintain case management services for adults

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/1/1. *Case Management*					
Value: # of adults receiving case management	**10,434**	**10,688**	**9,870**	**10,790**	**Exceeded 100%**
Denominator: '01 baseline	**9,870**	**9,870**	**9,870**	**9,870**	**9,870**

Objective I/2 A: Increase the number of adults served by PACT teams.

Brief Name: *PACT Team Services*

Indicator: the number of adults (Areas) served by a PACT team in each fiscal year

Measure: # of adults served by a PACT team
# of adults served by a PACT team at baseline (SFY'01)

Year 3: Increase the number of adults served by a PACT team by 387

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/1/2. *PACT teams*					
Value: # of adults receiving PACT team services	**255**	**540**	**727**	**741**	**Exceeded 100%**
Denominator: baseline	**142**	**142**	**142**	**142**	**142**

SFY'04 Accomplishments: **I/1/1:** Historically, DMH has reported both an unduplicated count of individuals who were case managed for any amount of time during the year and a point-in time number. In SFY'04, an unduplicated total of *10,790* adults (including *410* elders >65) received case management services - an increase overall of *920* adults over SFY'01, the base year and *102* over the previous year (SFY'03). The point-in-time number of clients receiving case management on June 30, 2004 was *9,196* adults, including elders. This compares with *8,981* adults and elders on June 30, 2001. Looked at this way, there were *215* more adults receiving case management services at a point-in-time in SFY'04 than at the same point in SFY'01. This represents an increase of *2.39%* since SFY'01, the baseline year. **Accomplished.**

I/1/2: For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and keep them out of the hospital, DMH has created Program for Assertive Community Treatment (PACT) teams. Since recipients of PACT services receive intensive care coordination from the team, these clients do not receive DMH case management services and are not included in the case management numbers above. In SFY'02, PACT teams were operating in four DMH Areas, and served *255* clients. In SFY'03, there were 13 PACT teams operating in the state, covering all DMH Areas and serving *540* clients. In SFY'04, the 13 PACT teams served *741* clients. Although budget cuts affected certain community programs, funding for PACT team development was preserved. The teams are still evolving, developmentally, and DMH will continue to support their growth as a successful and viable treatment option for appropriate DMH clients. The ultimate capacity for the 13 teams is *780* clients (at a point in time). Teams are currently staffed at 11.5 FTEs; goal is 13 or more FTEs per team. A**ccomplished.**

Goal I/2 A: Support adults with serious mental illness to live independently in the community.

Population: **Adults with serious mental illness**

Objective I/2 A: Increase the number of adults receiving residential services.

Brief Name: *Community Residential Services*

Indicator: The number of DMH clients receiving residential services in each fiscal year

Measure: # of adults receiving residential services each fiscal year
# of adults receiving residential services at baseline (SFY'01)

Year 3: Increase residential services for adults with serious mental illness by 2%

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/2/A. C*ommunity Residential Services*					
Value: # of adults receiving residential services	**8,009**	**8,429**	**7,513**	**7,261**	**96.6%**
Denominator: '01 baseline	**7,129**	**7,129**	**7,129**	**7,129**	

SFY'04 Accomplishments: DMH increased the number of adults receiving "Rehab Option" billable residential services this year by *1.85*% over SFY'01, although it fell slightly short of the SFY'04 target. In SFY'04, *6,975* adults and *286* elders received these services. (*Please note: 7,261 represents the unduplicated number of people receiving services, not residential bed capacity, which is different. The SFY'04 data are more accurate than those of previous years as a result of the data scrubbing that was conducted as part of the conversion from the Client Tracking System to the new Mental Health Information System.)* Residential services include a range of options from fully staffed group residences to supported housing and rental assistance. Although there were significant cuts to the Department's state appropriation in SFY'04, there were no cuts to residential services, and the closure of Medfield State Hospital the year before provided DMH with additional funds for residential service expansion and maintenance. In addition to services being delivered under the Rehab Option, DMH serves hundreds of clients living in their own homes through supported housing services provided by Clubhouses and other DMH community programs. In the last couple of years, block grant funding was made available to six Clubhouses, as a pilot project, to provide four to six members in each Clubhouse with flexible supports to help them move into their own apartments, thereby freeing up spaces in group homes and area homeless shelter programs. Each member receives first and last month's rent and a stipend until a Section 8 housing certificate can be secured. **Partially accomplished.**

Housing Training

DMH trained over 300 mental health workers through a series of trainings offered in all six DMH Areas on Section 8 Vouchers, Housing Search, and Fair Housing. The range of participants included case managers, residential staff, and housing search and other direct care positions within DMH and service provider organizations. The trainings were done in cooperation with the Citizens' Housing and Planning Association (CHAPA), a statewide educational and advocacy organization dedicated to affordable housing. Organizations that led the trainings included, the Technical Assistance Collaborative (TAC), a nationally recognized, Boston-based housing and homeless organization; HomeStart, the premier housing search group in Greater Boston that works with homeless shelters to place individuals and families into permanent housing and provides them with supports to remain in housing; and the Fair Housing Center of Greater Boston, which has evolved into a statewide agency working closely with HUD and housing organizations to protect the rights of those seeking rental housing.

Federal Housing Vouchers

This past spring, DMH collaborated successfully with a broad range of housing agencies to prevent federal funding cuts to the Section 8 Voucher program. Hundreds of people turned out to a hearing hosted by the Department of Housing and Community Development (DHCD) at the State House to voice their opposition to these funding cuts along with several members of the Massachusetts Congressional delegation. Governor Romney wrote to the HUD Secretary asking that the proposed cuts not be implemented which had a direct result in HUD's decision to level-fund the Section 8 program.

MassHousing Set-aside Units

DMH continues to work closely with MassHousing regarding the set-aside of units for DMH clients. Clients occupy nearly 400 units in residential buildings across the state. The rents for these units are capped at 30% of income making them affordable to clients. MassHousing continues to review the inventory to ensure that all units available to DMH are being utilized and accounted for. The set-aside agreement allocates 3% of low-income units to DMH and DMR clients.

Chapter 689/167 Special Needs Housing

Chapter 689/167 is the Special Needs Housing Program managed by DHCD to build housing in cooperation with local housing authorities. The operating costs are the responsibility of the sponsoring Department. Currently DMH operates *78* of these Chapter 689/167 developments across the state with a total capacity of *621* clients.

The Brockton project, which received site approval in SFY'03, has been delayed by budgetary issues and anticipates getting construction underway in SFY'05. It is also anticipated that a new project in Shrewsbury will receive DHCD approval in SFY'05.

Facilities Consolidation Fund

DMH made a concerted effort this past year to promote independent, integrated housing using the FCF. Presentations were made to senior DMH Area staff and housing developers in collaboration with CHAPA. DMH produced a new brochure that discussed integrated housing and the use of a range of financing tools. During SFY'04, there were

four new projects certified by DMH representing *23* units of housing and a financial commitment of approximately $1.5 million. This came at a time of great uncertainty with respect to the availability of federal Section 8 Vouchers and HUD's reluctance to provide project-based assistance to units that served DMH clients only. HUD's attempt to make administrative changes in the Section 8 Voucher Program coupled with their interpretation of Fair Housing and Project-based Assistance negatively impacted DMH's ability to attract interested development partners. Continued advocacy from the Governor's office and DHCD to maintain the Section 8 program is expected to help reinvigorate the FCF in the coming year.

Citizens Housing and Planning Association

This statewide educational and advocacy organization has assisted DMH in a number of housing-related activities. These included hosting a development forum in November 2003 with senior DMH Area staff from across the state to discuss the integrated housing model, examine available housing resources and outline recommendations for moving this concept forward.

CHAPA also hosted a meeting for not-for-profit and for-profit developers in June 2004 to present the integrated housing concept, seek their input and feedback on how DMH can better promote this model, and explore collaborations that will result in a set-aside of affordable units to serve DMH clients.

Goal I/3 A: Increase access to mental health services.

Population: **Adults with serious mental illness**

Objective I/3/1 A: Decrease waiting time from time of acceptance (eligibility determination) to start of services.

Brief Name: *Access to mental health services*

Indicator: the number of adults determined eligible in a given fiscal year who begin to receive services in that fiscal year; waiting period between eligibility determination and start of case management

Measure: # of adults found eligible in given fiscal year who received a DMH community service
# of adults found eligible for a DMH community service in given SFY

# of days between date of eligibility determination and start of case management for those who received case management

Year 3: At least *60%* of individuals found eligible for DMH services receive at least one community service in the same fiscal year; ensure that the waiting period between eligibility determination and the start of case management services, for those who are assigned to a case manager, does not exceed *60* days

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/3/1. *Access to Mental Health Services*					
Value: % eligible & received case management and/or a community service in the same fiscal year	**58.07%**	**48.3%**	**60%**	**86.6%**	**Exceeded 100%**
Denominator: # found eligible in fiscal year	**1,927**	**2,205**	**N/A**	**1,397**	
Value: # days wait between eligibility & start of case management	**39.6 days** (baseline)	**44.09 days**	**60 days**	**29 days**	**Exceeded 100%**

Objective I/3/2 A: Ensure that appropriately referred adults are admitted to state inpatient facilities.

Brief Name: *Inpatient admissions*

Indicator: the number of individuals admitted to state inpatient facilities in each fiscal year

Measure: # of admissions to state inpatient facilities
# of referrals to state inpatient facilities

Year 3: *80%* of adults referred to state inpatient facilities are admitted

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/3/2. *Inpatient Admissions*					
Value: % of adults appropriately admitted to extended stay inpatient services	**70%**	**71.4%**	**80%**	**75.36%**	**94.2%**
Denominator:	**515**	**577**	**N/A**	**483**	

SFY'04 Accomplishments: A principal measure of accessibility is the ease with which individuals are able to apply for services and the lengths of time they must wait before services are available. DMH has established baseline numbers for measuring its success in this arena for access and waiting times for community services, including case management. A separate indicator measures access to DMH's extended stay inpatient facilities.

I/3/1: After an individual applies for DMH eligibility and is determined by DMH to meet the clinical and other criteria, assignment to community services is based on the intensity of the person's need and the availability of services. Despite waiting lists for high demand and high intensity services, such as case management, PACT and residential, Areas report that many clients are assigned to one or more less intensive services while waiting. DMH improved its ability to assign clients to a community service as quickly as possible after being found eligible. **Accomplished.**

I/3/2: Admission to DMH extended stay inpatient facilities is based on published, uniform clinical criteria ("Clinical Criteria for Requesting Transfer to DMH Continuing Care Inpatient and Intensive Residential Treatment Facilities and Programs") and available beds. Referrals are accepted from all acute hospitals, including those that are part of the Massachusetts Behavioral Healthcare Partnership (MBHP) network as well as those that are not, and from the courts. The MBHP network serves Medicaid recipients and DMH-uninsured clients. Referrals of *non-forensic* patients who do not meet the clinical criteria are deemed to be inappropriate and are denied. An Interagency Service Agreement between DMH and DMA provides for an expedited response for MBHP enrollees.

Individuals denied admission because they do not meet the clinical criteria for admission either remain in the acute hospital or are diverted to other, less restrictive care settings, as appropriate. **Partially accomplished.**

Goal I/4 A: Ensure that DMH clients and/or guardians participate to the extent possible in treatment planning.

Population: **Adults with serious mental illness**

Objective I/4 A: Increase participation of adults in the development of their ISP.

Brief Name: *Participation in treatment planning*

Indicator: the percentage of DMH-eligible adults receiving services that participate in developing their Individual Service Plan (ISP) in each fiscal year

Measure: # of adults participating in the ISP process
# of adults with ISPs

Year 3: *85%* of individuals receiving services through an ISP will participate in its development

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/4. *Participation in Treatment Planning*					
Value: % of adults participating in developing their ISPs	**60%**	**63%**	**85%**	**95.6%**	**Exceeded 100%**
Denominator:	**6,785**	**5,490**	**N/A**	**1,288***	

*Data from three of the six DMH Areas.

SFY'04 Accomplishments: The requirements governing client and/or guardian participation in treatment planning, and client approval of the service plan are included in DMH regulations. All case managers received training on these regulations and were instructed in how to enter this information into the Client Tracking System (CTS). DMH is in the midst of a multi-year process of converting from CTS to the Department's new Mental Health Information System (MHIS). As of June 2004, five of the six DMH Areas had completed this conversion. Unfortunately, MHIS is not able to produce the information for this indicator because the module originally designed to track ISPs was not satisfactory and was never installed. Therefore, we have relied on a smaller sample, derived from CTS, from three Areas that were still using CTS for at least a significant portion of the fiscal year. In SFY'04, *1,288* ISPs completed for community clients in those three DMH Areas contained documentation that *1,232* clients or their guardians had participated in the ISP planning process. Last year, as a check on the system, we asked one of the two Areas that had converted to MHIS to analyze its participation data. They reported that *97%* of clients participated in the ISP process. In addition, the regulations and guidelines contain specific instructions for overcoming barriers to active client participation. **Accomplished.**

Goal I/5 A: Improve levels of functioning of DMH clients accessing and participating in treatment and rehabilitation.

Population: **Adults with serious mental illness**

Objective I/5 A: Increase level of functioning for inpatients and community clients.

Brief Name: *Improved functioning*

Indicator: **the percentage of adults receiving extended stay inpatient services and/or case management services with increased functioning at periodic reviews (inpatient) or at the annual Individual Service Plan (ISP) review (community) as measured by the CERF R (Current Evaluation of Risk and Functioning-Revised) in each fiscal year**

Measure: # adults on extended stay inpatient units with increased functioning on most recent CERF-R
# of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission

Measure: # of adults with an ISP with increased functioning at annual ISP review
# of adults with an ISP given the CERF-R who scored 4 or more on previous CERF-R

Year 3: Level of functioning at periodic review (inpatient) is increased in at least one domain where the patient scored a 5 or 6 at admission;

Level of functioning at ISP annual review (community) is increased in at least one domain where the client scored a 4, 5 or 6 on any of eight selected domains on the previous CERF-R. Implementation of the C-CERF (consumer-completed version) continues.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/5. *Improved Functioning*					
Value: % of adults with increased functioning (inpatient)	**60%**	**53%**	**80%**	**75%**	**93.8%**
Denominator:	**954**	**676**	**N/A**	**600***	
Value: % of adults with increased functioning (community)	**58%**	**53%**	**50%**	**66%**	**Exceeded 100%**
Denominator:	**3,439**	**2,569**	**N/A**	**1,182***	

*The Denominator includes only those clients who scored 4 or more in one of the community domains and 5 or more in one of the inpatient domains. It does not include all those who had more than one CERF-R performed.

SFY'04 Accomplishments: The CERF-R is used on all extended stay inpatient units and with every case managed DMH client in the community. A multidisciplinary team (inpatient) or team of providers and case manager (community) typically administers the CERF-R. CERF-R is administered to patients on inpatient units at the time of admission, at three and six-month periodic reviews, at the annual review and at discharge. CERF-R is administered to community clients at the time of ISP development and at the ISP annual review. The C-CERF is being piloted in Clubhouses by a consumer group and is being reviewed for inpatient use in the Metro Suburban Area.

C-CERF, a self-administered client tool, continues to be piloted in one DMH area and one inpatient setting in the Metro Suburban Area.

Recent research continues to reinforce the validity and reliability of the CERF-R tool. CERF-R assesses ten separate functional domains and seven risk domains. The eight functional domains that are most reflective of the ability to manage in the community were selected and analyzed for this report.

CERF-R uses a six-point scale. A score of 1 indicates the client is "fully" able to self-perform this function. A score of 4 indicates the client requires close supervision to "marginally" perform this function. A score of 5 indicates the client "rarely" performs this function without intense supervision or assistance and a score of 6 indicates that the client is "not able" to perform this function.

Community Clients			
CERF-R Functional Item	**# Clients who scored 5 or 6 on item in 1st Rating**	**# of Clients with a score of 5 or 6 at 1st Rating who improved their score at last Rating**	**% Who Improved on this Item**
Item A - Hygiene	195	97	50%
Item B - Nutrition	290	159	55%
Item E - Negotiate Social Situations	340	200	59%
Item F - Pursue Independence	621	343	55%
Item G - Use Recovery Services	361	221	61%
Item H - Use Psychiatric Meds	560	241	43%
Item I - Recognize/Avoid Common Hazards	180	124	69%
Item Q - Get and Use Medical Services	322	166	52%

Inpatients			
CERF-R Functional Item	**# Clients who scored 5 or 6 on item in 1st Rating**	**# of Clients with a score of 5 or 6 at 1st Rating who improved their score at last Rating**	**% Who Improved on this Item**
Item A - Hygiene	85	48	56%
Item B - Nutrition	130	66	51%
Item E - Negotiate Social Situations	166	104	63%
Item F - Pursue Independence	342	183	54%
Item G - Use Recovery Services	226	141	62%
Item H - Use Psychiatric Meds	500	191	38%
Item I - Recognize/Avoid Common Hazards	143	90	63%
Item Q - Get and Use Medical Services	275	179	65%

COMMUNITY SCORES: Scores of 4 or more were chosen as baseline data for community clients, as "marginal" performance can seriously hamper community adjustment. The percent of those scoring 4 or more that improved, ranged from *43%* for Item H – Use of Psychiatric Meds to 69% Item I – Recognize/Avoid Common Hazards. Overall, 66% of clients improved in at least one domain. This is the second year that the rate of improvement for Item H was below 50%. One DMH local area has developed a task force, led by the Area Medical Director, to review the issues related to this finding and to develop recommendations and strategies for improving performance.

INPATIENT SCORES: Patients with scores of 5 and 6 were selected to provide baseline data for analysis of inpatient improvement. The percent of inpatient improvement ranged from *38%* for "Use Psychiatric Meds" to 65*%* improvement for "Get and Use Medical Care." There was improvement in all domains, although none of the domains reached the 80% improvement level, set up as the proposed goal. After three years of collecting data, it appears this may have been unrealistic for our primarily long-stay population for the individual goals, although we are close to that figure (75%) for that number of clients attaining the goal in at least one domain. The 80% goal should be focused upon those clients who are in the process of discharge from the hospital. When the MHIS automated system is completely operational, DMH will split hospitalized clients between those who remain in the state hospitals and those are discharged to provide more detailed data on the outcomes of the two groups.

Goal I/6 A: Increase community tenure for DMH clients discharged from acute inpatient services.

Population: **Adults with serious mental illness**

Objective I/6 A: Reduce recidivism of adults discharged from CMHCs and acute care hospitals.

Brief Name: *Increased community tenure*

Indicator: the number of adults readmitted to acute inpatient care within 7 days of discharge

Measure: # adults discharged from DMH CMHCs readmitted w/in 7 days
# of adults discharged from DMH CMHCs

Measure: # adults discharged from MBHP network hospitals readmitted w/in 7 days
# of adults discharged from MBHP network hospitals

Year 3: Recidivism among adults discharged from DMH CMHCs and MBHP network hospitals is maintained at no more than *3%*

Indicator: the number of adults readmitted to acute inpatient care within 30 days of discharge

Measure: # adults discharged from DMH CMHCs readmitted w/in 30 days
# of adults discharged from DMH CMHCs

Measure: # adults discharged from MBHP network hospitals readmitted w/in 30 days
# of adults discharged from MBHP network hospitals

Year 3: Recidivism among adults discharged from DMH CMHCs is no more than *13%;* recidivism among patients discharged from MBHP network hospitals is no more than *18%*

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/6. *Increased Community Tenure*					
Value: % adults readmitted to CMHCs within: 7 days after discharge 30 days after discharge	 **3.9%** **9.6%**	 **4.6%** **9.1%**	 **3%** **13%**	 **5.28%** **9.35%**	 **Not met** **Exceeded 100%**
Denominator:	**790**	**834**	**N/A**	**673**	

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
Value: % adults readmitted to Medicaid network hospitals within:					
7 days after discharge	**3.24%**	**1.5%**	**3%**	**N/A***	
30 days after discharge	**19.71%**	**19.5%**	**18%**	**N/A***	
Denominator:	**10,050**	**10,098**	**N/A**		

SFY'04 Accomplishments: Most adults with serious mental illness receive acute inpatient services through the Department of Medical Assistance (DMA) and its behavioral managed care vendor, Massachusetts Behavioral Health Partnership (MBHP), in either the three DMH community mental health centers (CMHCs) that provide acute care or in approximately 60 MBHP network hospitals (private or general hospitals in the community). It is assumed, in most cases, that a readmission within 30 days indicates premature discharge or insufficient community support. DMH works with DMA and MBHP to achieve desired outcomes through performance improvement activities.

In SFY'04, the readmission rate to the three DMH-operated CMHCs within 7 days was *5.28%* (n = 39) and within 30 days was 9.35*%* (n = 39 + 30) based on *673* discharges for the year. It has declined from a (7-day) rate of 7.8% in SFY'98. The rates of the three facilities vary (from 2.35% to 7.12% for 7-day; and .59% to 5.57% for 30-day), but are averaged to arrive at the final number. **Partially accomplished**.

The readmission rates for the MBHP hospitals, based on claims data, are unavailable for SFY'04. MBHP was instructed by DMA to take the readmission reports out of production as part of its process of revising the reporting methodology for all 35 standard reports. As the reports are revised and reprogrammed, they will be put back into production. DMA expects this particular report to be available again in January 2005.

Goal I/7 A: Provide educational, employment and skill development opportunities to enhance self-esteem and increase independence.

Population: Adults with serious mental illness

Objective I/7/1-A: Increase the number of adults who are independently employed.

Brief Name: *Employment*

Indicator: the number of adults in DMH-sponsored employment programs placed in jobs

Measure: # of adults from DMH-sponsored employment programs employed
# of adults participating in DMH-sponsored employment programs (SEE & Clubhouse)

Year 3: *55.08%* of adults participating in DMH-sponsored employment programs (SEE) are placed in jobs outside the program; 48% of adults participating in Clubhouse employment programs are placed in jobs outside the program.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/7/1. *Employment*					
Value: % of adults employed (SEE programs)	**57.2%**	**56.2%**	**55%**	**50.25%**	**91.4%**
Denominator: (SEE clients)	**2,631**	**2,455**	**N/A**	**997**	
Value: % of adults employed (Clubhouse programs)	**48.3%**	**48.1%**	**48%**	**69.9%**	**Exceeded 100%**
Denominator: (Clubhouse members)	**5,626**	**5,418**	**N/A**	**2,944****	

** this is an unduplicated count of Clubhouse members participating in a Clubhouse employment program who are either independently employed or in a supported employment position outside the Clubhouse. Adults are not required to apply for DMH eligibility to attend a DMH-funded Clubhouse program. However, these individuals may also have participated in a SEE program if they are DMH clients. DMH is working to produce an entirely unduplicated count of individuals in employment programs.

Objective I/7/2-A: Increase the number of adults who attain set educational goals.

Brief Name: *Supported Education*

Indicator: the number of adults in DMH-sponsored education programs who achieve stated educational goals

Measure: # of adults in DMH-sponsored education programs who achieve stated educational goal(s)
# of adults participating in DMH-sponsored education programs (SEE only)

Year 3: *55.8%* of adults participating in DMH-sponsored education programs that achieve stated educational goal(s)

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/7/2. *Supported Education*					
Value: % adults who achieve their educational goals (SEE only)	**46.6%**	**75.7%**	**55.8%**	**73.4%**	**Exceeded 100%**
Denominator:	**993**	**624***	**N/A**	**699**	

*This is an unduplicated count of DMH clients participating in a SEE education program.

SFY'04 Accomplishments: The SEE program (Services for Employment and Education) is a flexible, community-based service that provides access to an array of skill training, employment and educational opportunities for DMH clients. Clubhouses also provide a range of employment services, including transitional, supported, and independent employment, as well as GED preparation, supported education and skill development programs. The majority of funding for Clubhouses is provided by DMH, and the Clubhouses abide by standards established by DMH. However, although most Clubhouse members are referred by DMH and meet DMH eligibility requirements, members are not required to formally apply for DMH client eligibility in order to participate in the Clubhouse program. In SFY'04, there was an unduplicated count of *8,634* Clubhouse members. Outcomes related to education skills in this report (Indicator I/7/2) are based on the SEE program only. Education programs in Clubhouses are not included. **Partially accomplished**.

Goal I/8 A: Promote health and wellness opportunities for DMH clients

Population: Adults with serious mental illness

Objective I/8 A: Reduce smoking among a voluntary group of community clients.

Brief Name: *Smoking Cessation and Reduction*

Indicator: the number of DMH clients in a pilot program who stop or reduce smoking

Measure: # of adults who stop smoking
# of adults who participate in the pilot program

Year 3: *50%* of the individuals in the pilot group (n=100) who quit during active treatment will remain abstinent from smoking at six-month follow up.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/8. *Smoking Cessation and Reduction*					
Value: % adults who reduce or quit smoking	**Begin to recruit a pilot group**	**45% quit at end of 12-week program;** **50% reduced smoking**	**50% will be abstinent at 6-mo. follow up**	**30-48% cessation rate; <50% remained abstinent at follow-up.**	**Established baseline for continued research. See text below**
Denominator:	**N/A**	**46**	**N/A**	**114**	

SFY'04 Accomplishments: People with serious mental illness smoke at significantly higher rates than people in the general population. Two DMH Mortality Reports (2001 and 2002), based on a review of DMH client deaths in 1998-1999 and 2000, revealed that significantly more people with serious mental illness die from cardiovascular and respiratory illness than people of the same age in the general population. Cigarette smoking is thought to be an important causal factor for this premature mortality for patients with major mental illness, and successful smoking cessation programs could significantly reduce this burden. The goal of smoking cessation in this population is complicated by the fact that nicotine may provide clinical benefit and smoking cessation may have transient or lasting negative clinical consequences for people with some mental illnesses. Therefore, clinicians have proceeded cautiously. A DMH-affiliated psychiatrist with expertise in studying smoking cessation with this population has embarked on a three-year well-controlled and carefully supervised smoking cessation treatment program for DMH clients with schizophrenia living in the community. Clients from various outpatient settings around the state who volunteer for this program receive

group counseling by a tobacco treatment specialist, pharmacologic treatment for smoking cessation, and careful clinical monitoring during their smoking cessation attempt. Clients receive either nicotine patch/gum (NRT) alone or NRT combined with Zyban, medication that may work to prevent or reduce negative clinical consequences of smoking cessation and improve smoking cessation rates in this population. All clients receive counseling. The Department of Public Health has developed the counseling program in collaboration with UMass faculty and has trained mental health clinicians to deliver the treatment. Many levels of clinical support are built into the program, and separate research grant funding is being used to document the outcome in terms of smoking cessation and stability of clinical symptoms. The performance measures are based on data from a previous small pilot smoking cessation treatment program with this population.
To date, the project has been run at four sites: Freedom Trail Clinic in Boston, UMass in Worcester, Child and Family Services in New Bedford and North Central Human Services in Gardner.

Outpatients with schizophrenia who smoked more than 10 cigarettes per day and wished to quit smoking were randomly assigned to receive bupropion SR 300 mg per day or identical placebo for 12 weeks. All participants received 12 weeks of CBT (counseling), set a quit date after study week 4, and received 8 weeks of NRT beginning on the quit date. The primary outcome measure was the rate of significant smoking reduction at the end of the intervention, defined as expired air carbon monoxide (CO) <9ppm and CO < 50% of baseline on two occasions in week 12. Secondary outcome measures included 7-day point prevalence abstinence at weeks 8 and 12 and at the 3-month follow up.

Fifty-one subjects were enrolled and randomized. Subjects on bupropion + NRT + CBT had a higher rate of significant smoking reduction at week 12, 48% (12/25) vs. 19% (5/26), Chi2= 4.75, p=0.029. Those on bupropion + NRT had a significantly higher abstinence rate while on full dose NRT (week 8), (48% (12/25) vs. 19% (5/26), Chi2=4.74, p=0.029. Those on bupropion + NRT had a trend toward a higher rate of 4 week continuous abstinence during the trial, 40% (10/25) vs. 19% (5/26), Chi2=2.65, p=0.10. Following taper of NRT, the difference in abstinence rates was no longer significant. The abstinence rates were 28% (7/25) in the bupropion group and 15% (4/26) in those on placebo at week 12, 20% (5/25) and 11.5% (3/26) at week 14, and 8.0% (2/25) and 7.7% (2/26) at the 3-month follow up.

The 7-day point prevalence abstinence rate in the group as a whole was 33.3% prior to taper of NRT and 21.6% at the end of the intervention when NRT had been tapered.

We had projected a 20% 7-day point prevalence smoking cessation rate. Subjects who dropped out of the study were considered smokers for the analysis. Subjects in the bupropion + NRT group had a greater mean reduction in expired air CO than subjects randomized to placebo and NRT, (weeks 6-24), F=5.09, p=0.03.

In the training portion of the project, eight clinicians completed the basic skills portion of the UMass tobacco treatment specialist training program, and six clinicians completed the entire core training program and became certified tobacco treatment specialists. In the coming year we plan to train an additional ten people in the basic skills training that is now available as a self-paced online course with 12 CEUs available for nurses, certified health education specialists and certified substance abuse counselors. CEUs are pending for LICSWs and to have an additional two clinicians complete the entire core training program.

The majority of patients with schizophrenia report that they are not ready to try to quit smoking in the next month. In addition to the trial of pharmacologic interventions in patients with schizophrenia who are ready to try to quit smoking, the researchers have developed and implemented a pilot-controlled trial of a motivational enhancement intervention for smokers with major mental illness who state that they are not ready to try to quit smoking. This pilot trial is designed to compare a personalized motivational enhancement intervention with an educational intervention for people in the pre-contemplation stage of readiness to quit smoking. Patients enrolled state that they are not ready to change their smoking behavior in the next 30 days. The primary outcome measure is whether or not any action is taken to obtain smoking cessation treatment within 30 days of the end of the study intervention. Secondary outcome measures are: 1) smoking cessation; 2) reduction in expired air CO; 3) change in a measure of self-efficacy to change behavior, a measure of how confident the person is that he/she could successfully stop smoking. This is a one-month intervention with a one-month follow up period. To date, 34 subjects have been randomized and have completed at least one group and 32 have completed the 1-month follow up.

Seventy-five percent (24/32) of subjects who have completed the program sought further smoking cessation treatment within one month of finishing the intervention. The target is to enroll 40 subjects into this pilot program.

In our studies to date, we have demonstrated that patients with schizophrenia are able to pursue a smoking cessation program. Our two trials have included *114* subjects. We have had an *82%* attendance rate in our two trials. We have demonstrated that patients with schizophrenia can quit smoking acutely. We have had a 30-48% cessation rate during the trials. But we have also discovered that the relapse rate following discontinuation of pharmacotherapy for smoking cessation is high. The public health benefit from smoking cessation comes from long term abstinence. In the next three years, we will design and implement a large multi-center trial to study interventions designed to reduce the *rate of relapse* to smoking following a period of abstinence in patients with schizophrenia. It has been shown that patients with schizophrenia have abnormally low expression of nicotinic acetylcholine receptors (nAChR) in relevant brain areas, that expressed nAChRs have reduced functioning and that nicotine has acute beneficial effects on attention and concentration in patients with schizophrenia. While we have found that patients with schizophrenia do not decompensate clinically in early nicotine abstinence, it is possible that following withdrawal of bupropion or nicotine replacement therapy, abstinent subjects experience a decline in cognitive functioning. In SFY'05, we will begin a relapse prevention trial for smokers with schizophrenia who are able to quit smoking using NRT, bupropion or both. In SFY'05, we will also complete the 40 subjects in the Enhance program and will analyze the results of that trial. We will then design and implement a full-scale intervention for the majority of smokers with major mental illness who are in the pre-contemplation phase of change. The intervention will be designed to move patients from pre-contemplation phase of behavioral change toward the action phase when they are likely to be able to take advantage of a smoking cessation intervention. **Accomplished.**

CRITERION I - CHILD/ADOLESCENT PERFORMANCE INDICATORS

Comprehensive Community-based Mental Health Service System

Goal I/1 C-A: Increase community tenure for children and adolescents discharged from acute inpatient services

Population: Children and adolescents with serious emotional disturbance

Objective I/1 C-A: Reduce recidivism of children and adolescents discharged from acute care hospitals.

Brief Name: *Increased community tenure*

Indicator: the number of children and adolescents (C/A) readmitted to acute inpatient care within 30 days of discharge

Measure: # C/A discharged from MBHP network hospitals readmitted w/in 30 days
# of C/A discharged from MBHP network hospitals

Year 3: No more than *13%* of patients discharged from MBHP network hospitals will be readmitted within 30 days of discharge

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/1. *Increased Community Tenure*					
Value: % **children** readmitted to MBHP network hospitals within 30 days after discharge	**13.62%** children & adolescents	**11.9%** (children only)	**13%**	**N/A**	
Denominator:	**2,845**	**1,471**	**N/A**		
Value: % of **adolescents** readmitted to MBHP network hospitals within 30 days after discharge	**N/A**	**14.7%** (adolescents only)	**13%**	**N/A**	
Denominator:	**N/A**	**1,938**	**N/A**		

SFY'04 Accomplishments: Many children and adolescents receive acute inpatient services through the Department of Medical Assistance (DMA) and its behavioral managed care vendor, Massachusetts Behavioral Health Partnership (MBHP), in MBHP network hospitals (private and general hospitals in the community). There is concern that readmission within 30 days may be an indicator of premature discharge or inadequate

aftercare. One factor that must be considered is the consequence of placing a child in a hospital far from home (due to lack of a closer bed), resulting in less preparation of family and providers for reintegration. DMH works with DMA and MBHP to achieve desired outcomes through performance improvement activities.

The readmission rates for the MBHP hospitals, based on claims data, are unavailable for SFY'04. MBHP was instructed by DMA to take the readmission reports out of production as part of its process of revising the reporting methodology for all 35 standard reports. As the reports are revised and reprogrammed, they will be put back into production. DMA expects this particular report to be available again in January 2005.

Goal I/2 C-A: Ensure that DMH parents and/or guardians participate in treatment planning

Population: **Children and adolescents with serious emotional disturbance**

Objective I/2 C-A: Increase participation of parents and/or guardians in the development of their child's/ward's ISP.

Brief Name: *Participation in treatment planning*

Indicator: **the percentage of legally authorized representatives (parents and guardians) who participate in treatment planning for DMH eligible children and adolescents under 18**

Measure: # of ISPs developed with legally authorized representatives' participation
# of children and adolescents with ISPs

Year 3: *100%* of the legally authorized representatives of children/adolescents receiving services through an ISP will participate in its development

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/2. *Participation in Treatment Planning*					
Value: % families who participate in developing child's ISP	**47%**	**98%**	**100%**	**87.9%**	**87.9%**
Denominator:	**950**	**one Area only**	**N/A**	**514***	

*Data from three of the six DMH Areas.

SFY'04 Accomplishments: The requirements governing client and/or guardian participation in treatment planning, and approval of the service plan are included in DMH regulations. DMH is in the midst of a multi-year process of converting from the Client Tracking System (CTS) to a new Mental Health Information System (MHIS). As of June 2004, five of the six DMH Areas had completed this conversion. Unfortunately, the MHIS module originally designed to track ISPs was unsatisfactory and was never installed. Therefore, we have relied on a smaller sample from three Areas that were still using CTS for at least a significant portion of the fiscal year. In SFY'04, *504* ISPs completed for community clients in those three DMH Areas contained documentation that *452* parents or guardians had participated in the ISP planning process. Last year, as a check on the system, we asked one of the two Areas that had converted to MHIS to analyze its participation data. They reported that *98%* of parents and guardians participated in the ISP process. In addition, the regulations and guidelines contain specific instructions for overcoming barriers to active client participation. DMH requires *100%* of parents and/or guardians of minors (under 18 years of age) to authorize treatment unless the child has been deemed an emancipated minor. Therefore, it is likely that the 12.1% differential is made up in large part of clients between 18 and 19 years of age, and a small number of emancipated minors. **Accomplished.**

Goal I/3 C-A: Provide case management services for children and adolescents

Population: **Children and adolescents with serious emotional disturbance**

Objective I/3 C-A: Maintain the number of children and adolescents receiving case management services.

Brief Name: *Case management services*

Indicator: the number of children and adolescents that receive case management services during each fiscal year

Measure: # of children/adolescents receiving case management services each year
# of children/adolescents receiving case management services in SFY'01

Year 3: Maintain case management services for children and adolescents

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/3. *Case Management*					
Value: # children receiving case management services	**1,875**	**1,975**	**1,916**	**1,933**	**Exceeded 100%**
Denominator: baseline ('01)	**1,916**	**1,916**	**1,916**	**1,916**	**1,916**

SFY'04 Accomplishments: Historically, DMH has reported an unduplicated count of individuals who were case managed for any amount of time during the year. In SFY'04, an unduplicated total of *1,933* children and adolescents received case management services - an increase of *15* individuals compared to SFY'01, the base year. These are the numbers reflected in the table. Although state-operated case management services have been preserved in recent years despite significant budget cuts, there are no future guarantees. DMH also is reporting the point-in-time number of clients receiving case management on June 30, 2004 (*1,408*). Child and adolescent case management is deliberately becoming more family-focused, which may decrease caseload size. **Accomplished.**

Goal I/4 C-A: Increase access to mental health services

Population: Children and adolescents with serious emotional disturbance

Objective I/4/1 C-A: Decrease waiting time from time of acceptance (eligibility determination) to start of services.

Brief Name: *Access to mental health services*

Indicator: the number of children/adolescents determined eligible in a given fiscal year who begin to receive services in that fiscal year; waiting period between eligibility determination and start of case management

Measure: # of C/As found eligible in given fiscal year who received a DMH community service in that fiscal year
# of C/As found eligible for a DMH community service in given SFY

Measure: # of days between date of eligibility determination and start of case management for those who received case management

Year 3: At least 5*0%* of children and adolescents found eligible for DMH services receives at least one community service in the same fiscal year. Ensure that the waiting period between eligibility determination and the start of case management services, for those who are assigned to a case manager, does not exceed 7*0* days

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/4/1. *Access to Mental Health Services*					
Value: % eligible & received case management and/or a community service in fiscal year	**40.5%**	**55.5%**	**50%**	**76%**	**Exceeded 100%**
Denominator:	**1,012**	**1,130**	**N/A**	**917**	
Value: #days between eligibility and start of case management	**57 days**	**58.87 days**	**70 days**	**40**	**Exceeded 100%**

Objective I/4/2 C-A: Decrease waiting time for admission to intensive residential treatment programs.

Brief Name: *Access to intensive residential treatment*

Indicator: the length of waiting time for children and adolescents (C/A) seeking admission to statewide intensive residential programs

Measure: median # of days on IRTP wait list (from time of acceptance)
median # of days on IRTP wait list (from time of acceptance) in SFY'01

Measure: median # of days on CIRT wait list (from time of acceptance)
median # of days on CIRT wait list (from time of acceptance) in SFY'01

Year 3: The length of waiting time is maintained at the SFY'02 level or improved

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/4/2. *Access to intensive residential treatment services*					
Value: # days on IRTP wait list	**52**	**39**	**45**	**25**	**Exceeded 100%**
Value: # days on CIRT wait list	**20**	**49.5**	**25**	**14.9**	**Exceeded 100%**

SFY'04 Accomplishments: A principal measure of accessibility is the ease with which individuals are able to apply for services and the lengths of time they must wait before services are available. DMH has established baseline numbers for measuring its success in this arena for access and waiting times for community services, including case management. A separate indicator specifically addresses access to the statewide programs (Intensive Residential Treatment Programs, including Behaviorally Intensive Residential Treatment programs for adolescents, and Clinically Intensive Residential Treatment programs for younger children).

1/4/1: After a child or adolescent is determined eligible for DMH services, assignment to community services is based on the intensity of the person's need and service availability. Despite waiting lists for high demand and high intensity services, such as case management and residential services, Areas report that most clients are assigned to one or more less intensive services while waiting. In SFY'04, *76*% of children and adolescents determined to be eligible for DMH community services (n = 917) were assigned to at least one community service by June 30, 2004. Similarly, of those assigned to case management services, the average wait for assignment to a case manager was *40* days. **Accomplished.**

1/4/2: Access to the statewide programs is limited to children and adolescents from acute care hospitals and DYS facilities. There is a process in place, with timelines, for processing applications to these programs. A child is accepted and placed on the wait list only when DMH receives a complete application and judges that all appropriate acute care interventions have been made. DMH was able to improve access to its statewide (adolescent) intensive residential treatment programs in SFY'04 and reduced the average number of days on the waitlist from 45 to 25 days. The average number of days on the waitlist for admission to the CIRT (younger children) program also was reduced, from 49.5 (this number was due to an outlier) to 14.9 days. **Accomplished.**

Goal I/5 C-A: Improve levels of functioning of DMH clients accessing and participating in treatment and rehabilitation.

Population: **Children and adolescents with serious emotional disturbance**

Objective I/5 C-A: Improve level of functioning of children & adolescents receiving community services.

Brief Name: *Improved functioning*

Indicator: **The percentage of DMH-eligible children/adolescents receiving case management services with increased functioning at the annual Individual Service Plan (ISP) review as measured by the CAFAS (Child and Adolescent Functioning Assessment Scale)**

Measure: # of children/adolescents with an ISP with increased functioning
# of children/adolescents with an ISP given the CAFAS

Year 3: CAFAS is administered to all children and adolescents when they apply for eligibility for DMH continuing care community services and is used to assist in the development of the ISP. It is administered again at the time of the ISP annual review. Level of functioning at annual review is increased compared to baseline (eligibility determination).

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/5. *Improved Functioning*					
Value: % children with increased functioning	**59.4%**	**49.8%**	**50%**	**55.8%**	**Exceeded 100%**
Denominator:	**281**	**305**	**N/A**	**364**	

SFY'04 Accomplishments: The CAFAS is used with every case managed DMH client in the community, at the time of eligibility determination (ISP development) and again at the time of the ISP annual review. DMH case managers have been specially trained to administer the CAFAS. Administering the CAFAS to all children at the time of annual review was implemented in January 2001. In SFY'04, a comparison of scores indicated that *55.8%* of children had measurably increased functioning (203 of 364), and *16.5%* maintained functioning (60 of 364). Although we were able to compare the two sets of scores for each child to determine level of functioning (i.e., increased or decreased), there is insufficient research and/or data to set a percentage goal for improvement or to predict whose functioning will improve as demonstrated on CAFAS. The CAFAS score may help case managers and clinicians assess the appropriateness of the service array. **Accomplished.**

Goal I/6 C-A: Provide educational and employment opportunities for transition age youth

Population: Transition aged youth with serious emotional disturbance

Objective I/6 C-A: Establish supported education and training programs for transition aged youth

Brief Name: *Educational and vocational outcomes*

Indicator: # transition aged youth enrolled in supported education and training programs

Measure: # of transition aged youth enrolled in supported education and training programs

Year 3: Maintain the number of transition aged youth enrolled in supported education and training programs

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/6. *Supported Education and Training*					
Value: # transition-aged youth enrolled in supported education and training programs	**30**	**30**	**30**	**48**	**Exceeded 100%**

SFY'04 Accomplishments: Most young adults who have been served through the child-adolescent system aspire to become independent. In order to further that goal, DMH would like to expand the availability of targeted supported education and training services specifically geared to transition aged youth. Currently, there is one very successful program in the Metro Suburban Area, as reported above. Due to budget cuts in SFY'02, SFY'03 and SFY'04, DMH has been unable to expand this program to other Areas.

In addition to the Metro Suburban Area program, the North East Area has established a peer mentoring program to provide individualized assistance to transition-age youth around employment and housing issues. Clubhouses across the state are also increasingly interested in working with young adults to help them achieve their goals, particularly in the areas of GED preparation, supported education and skill training. One Clubhouse, Genesis Club, has a staff person to work exclusively with this population. **Accomplished.**

CRITERION I - ADULT PERFORMANCE INDICATOR TABLE
Comprehensive Community-based Mental Health System

SFY 2004 Implementation Report

Population: Adults with Serious Mental Illness

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
I/1/1. *Case Management*				
Value: # of adults receiving case management	**10,434**	**10,688**	**9,870**	**10,790**
Denominator:	**9,870**	**9,870**	**9,870**	**9,870**
I/1/2. *PACT teams*				
Value: # of adults receiving PACT team services	**152**	**540**	**727**	**741**
Denominator:	**142**	**142**	**142**	**142**
I/2. *Community Residential Services*				
Value: # of adults receiving residential services	**8,009**	**8,429**	**7,513**	**7,261**
Denominator:	**7,129**	**7,129**	**7,129**	**7,129**
I/3/1. *Access to Mental Health Services*				
Value: % eligible & received case management and/or a community service in fiscal year	**58.07% (1,119)**	**48.3% (900)**	**60%**	**86.6%**
Denominator: # found eligible in fiscal year	**1,927**	**2,220**	**N/A**	**1,397**
Value: # days wait between eligibility & start of case management	**39.6**	**44.09**	**60**	**29**
I/3/2. *Inpatient Admissions*				
Value: % adults appropriately admitted to extended stay inpatient services	**70%**	**71.4%**	**80%**	**75.36%**
Denominator:	**515**	**577**	**N/A**	**483**

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
I/4. *Participation in Treatment Planning*				
Value: % adults participating in developing their ISPs	**60%**	**63%**	**85%**	**95.6%**
Denominator:	**6,785**	**5,490**	**N/A**	**1,288 (3 areas)**
I/5. *Improved Functioning*				
Value: % adults with increased functioning (inpatient)	**60%**	**53%**	**80%**	**75%**
Denominator:	**954**	**676**	**N/A**	**600**
Value: % adults with increased functioning (community)	**58%**	**53%**	**50%**	**66%**
Denominator: (baseline) from one community site	**3,439**	**2,569**	**N/A**	**1,182**
I/6. *Increased Community Tenure*				
Value: % adults readmitted to CMHCs: within 7 days after discharge within 30 days after discharge	**3.9%** **9.6%**	**4.6%** **9.1%**	**3%** **13%**	**5.28%** **9.35%**
Denominator:	**790**	**834**	**N/A**	**673**
Value: % adults readmitted to MBHP network hospitals: within 7 days after discharge within 30 days after discharge	**3.24%** **19.71%**	**1.5%** **19.5%**	**3%** **18%**	**N/A** **N/A**
Denominator:	**10,050**	**10,098**	**N/A**	
I/7/1. *Employment*				
Value: # of adults employed SEE: Clubhouse:	 **1,505** **2,717**	 **1,380** **2,606**	 **55%** **48%**	 **50.25%** **69.2%**
Denominator: SEE: Clubhouse:	 **2,631** **5,626**	 **2,455** **5,418**	**N/A**	 **997** **2,944**

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
I/7/2. *Supported Education*				
Value: # of adults who achieve their educational goals (SEE only)	**463 (46.6%)**	**472 (75.7%)**	**55.8%**	**513 (73.4%)**
Denominator:	**993**	**624**	**N/A**	**699**
I/8. *Smoking Cessation and Reduction*				
Value: # adults who reduce or quit smoking n = 100	**Pilot group recruited**	**45%** quit after 12-week program**;** **50%** reduced smoking	**50%** of pilot group will be abstinent at 6-month follow up	**30-48%** cessation; **<50%** remained abstinent at follow-up
Denominator:	**N/A**	**46**	**100**	**114**

CRITERION I - C/A PERFORMANCE INDICATOR TABLE
Comprehensive Community-based Mental Health System

2004 Implementation Report

Population: Children with Serious Emotional Disturbance

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
I/1. *Increased community tenure*				
Value: : % children readmitted to MBHP network hospitals within 30 days after discharge	**13.62%**	**11.9% (children) 14.7% (adolescents)**	**no more than 13%**	**N/A**
Denominator: children & adolescents Children: Adolescents:	**2,845**	 **1,471** **1,938**	**N/A**	**N/A**
I/2. *Participation in treatment planning*				
Value: % of families who participate in developing child's ISP	**47%**	**98%**	**100%**	**87.9%**
Denominator:	**950**	**N/A**	**N/A**	**514 (3 areas)**
I/3. *Case management*				
Value: # children receiving case management services	**1,916**	**1,916**	**1,916**	**1,933**
Denominator:	**1,875**	**1,975**	**1,916**	**1,916**
I/4/1. *Access to mental health services*				
Value: % eligible & received case management and/or a community service in fiscal year	**40.5%**	**55.5%**	**50%**	**76%**
Denominator:	**1,012**	**1,130**	**N/A**	**917**
Value: # days between eligibility & start of case management	**57**	**58.87**	**70**	**40**

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
I/4/2. *Access to intensive residential treatment services*				
Value: # days on IRTP wait list	**52**	**39**	**45**	**25**
Denominator:	**24**	**24**	**24**	**24**
Value: # days on CIRT wait list	**20**	**49.5**	**25**	**14.9**
Denominator:	**38**	**38**	**38**	**38**
I/5. *Improved Functioning*				
Value: % children with increased functioning	**59.4%**	**49.8%**	**50%**	**55.8%**
Denominator:	**281**	**305**	**N/A**	**364**
I/6. *Supported Education and Training*				
Value: # transition aged youth enrolled in supported education and training programs	**30**	**30**	**30**	**48**

CRITERION II: ADULT PERFORMANCE INDICATORS

Mental Health System Data Epidemiology

Goal II/1 A: Increase access to community-based mental health services

Population: **Adults with serious mental illness**

Objective II/1-A: Increase the number of DMH clients who receive a continuing care community service.

Brief Name: *Access to community-based services*

Indicator: **the percentage of adults who receive a continuing care community mental health service each fiscal year**

Measure: # of adults who received a DMH continuing care community service
prevalence estimate (#) of adults with SMI and severe dysfunction

Year 3: *46.5%* of the estimated number of adults with SMI will receive at least one DMH community service.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
II/1. *Access to Community-based Services*					
Value: % adults receiving case management and/or community rehab support services from DMH	**47.7%**	**43.5%**	**46.5%**	**39.8%**	**85.6%**
Denominator: prevalence of SMI	**46,683**	**46,683**	**46,683**	**46,683**	

SFY'04 Accomplishments: In SFY'01, *20,914* adult clients (an unduplicated number) received case management, residential (Rehab Option-billable) or another community service from DMH, insofar as the DMH Client Tracking System (CTS) was able to measure. Data from the new Mental Health Information System (MHIS) reported that *18,564* adults received these services in SFY'04. The number includes clients receiving PACT team services, but does *not* include individuals receiving inpatient services, outpatient (only) services, forensic services, or Clubhouse members (if Clubhouse is the only service they use). There are approximately *8,634* Clubhouse members across the state.

Several factors may account for the decline in numbers of people served, as reported by the tracking system. As the conversion from CTS to MHIS proceeds, Areas have been asked to verify client status and to ensure that every client entered into the system is in fact actively engaged in receiving DMH services. The records of non-active clients have been removed, as were the records of individuals receiving services that were not funded by DMH. In addition, the requirements concerning data-entry for non-case managed

community clients have led to what is believed to be a significant undercount of this population, a problem exacerbated by staff reductions. When the rate of those receiving services is calculated using *eligibility* as the denominator, then *93.7%* of eligible clients received at least one DMH community service.

The enrolled population ("DMH client") refers to those individuals who are determined to be eligible for continuing care community services, for whom no other options, outside of DMH, exist. DMH services included in the above count are residential, PACT, case management, day, outpatient, education and employment services, and other community services, such as community rehabilitation support. After being found eligible to receive DMH community services, each individual is assigned to services according to priority of need. If no appropriate community service is available, the individual is placed on a waiting list and is contacted on a regular basis regarding wait status. Clubhouse members and adults in need of outpatient services only are not required to apply for eligibility in order to participate in those programs and these individuals are not included in the tracking system, even though DMH funds the programs. **Partially accomplished.**

DMH, through its Forensic Division, also provides services to individuals involved with the criminal justice system. During SFY'04, DMH provided a total of *14,784* services to *8,512* individuals in *86* different courts (District, Superior and Boston Municipal Courts). Of these, *6,647* were statutory evaluations under MGL Chapter 123 for competency to stand trial, criminal responsibility, aid in sentencing and civil commitments for mental illness or substance abuse. The remaining services consisted of non-statutory evaluations, consultations, referrals and liaison activities.

In SFY'04, the Forensic Transition Teams served *516* inmates, including *218* post-release clients with mental health service plans, *173* pre-trial tracking cases, and *125* inmates still incarcerated. Participants had significantly lower recidivism rates than other inmates. Recidivism rates on the *218* post-release cases (*201* clients) released in SFY'04 and followed by the FTT show that *186* (92%) were not re-incarcerated, *10* (5%) were incarcerated within three months post-release at least once, and *5* (2.5%) were incarcerated after three months post-release at least once. Recidivism is defined as convicted and sentenced.

Although budget cuts forced DMH to stop providing mental health services to county houses of correction several years ago, DMH continued to provide technical assistance to the Massachusetts Sheriff's Association to complete a study of mental health services in county facilities. In SFY'04, this study was presented to the Legislature (Health Committee) as part of an effort on the Association's part to advocate for inmate mental health services. In addition, upon request, DMH has conducted post-mortem peer reviews for Department of Correction staff after a suicide or other adverse event in its system.

Prevalence and the DMH Target Population

Although all of the Department's eligible adult clients meet the criteria established in the federal definition of "serious mental illness," the DMH target population - people with serious mental illness with severe dysfunction or substantial functional impairment and likely to seek or use publicly funded mental health services - represents only a subset of the planning population covered by the definitions. For example: DMH is now a provider of continuing rather than acute care, therefore a DMH client is defined as someone receiving continuing care services. Also, individuals in Massachusetts with

particular diagnoses do not fall under the statutory responsibility of DMH, such as people with Alzheimer's disease and those with primary substance abuse disorders. They receive services through DPH. However, individuals dually diagnosed with mental illness and substance abuse disorder are eligible for DMH continuing care community services, regardless of which diagnosis is primary.

DMH will continue to depart from the federal definition and consider individuals 19 years of age and older as part of the adult planning population. Eighteen year-olds are counted as part of the child/adolescent population. This has been the operative age definition in Massachusetts since 1988.

Since 1990, the Massachusetts Department of Mental Health has based its prevalence estimates for adults (age 19+) on its own NIMH-funded study. Prevalence was based on three separate categories: adults with a diagnosable mental illness (*15.22*%); adults with a diagnosable mental illness and accompanying dysfunction in one of the four basic functional domains (*5.34*%); and adults with a diagnosis of serious mental illness with dysfunction in basic self care (*.98%).*

With the publication of a new prevalence estimation methodology for adults by the Center for Mental Health Services in March 1997, the Department changed the first two categories to match the CMHS definitions:

- prevalence of serious mental illness in Massachusetts – *5.7* percent
- prevalence of serious and persistent mental illness in Massachusetts – *2.6* percent

DMH will continue to use the third category, adults with serious mental illness and severe dysfunction in basic self-care (.98%) to define its target population. Last year, DMH updated its adult prevalence estimates using 2000 census data. Calculations for the last column (.98%) have been weighted to reflect two variables, poverty and percentage of divorced males, both of which have been determined in research studies to accurately predict the prevalence of serious mental illness in the adult population.

Prevalence Estimates for Adults (2000 census)

DMH Area	**Adults with Serious Mental Illness (5.7%)**	**Adults with Serious and Persistent Mental Illness (2.6%)**	**Adults with Serious & Persistent Mental Illness and Severe Dysfunction* (.98%) (weighted)**
Western Mass	35,004	15,967	**6,024**
Central Mass	32,894	15,004	**5,650**
North East	53,371	24,344	**9,173**
Metro Boston	41,966	19,142	**7,236**
Metro Suburban	55,876	25,487	**9,592**
Southeastern Mass	52,413	23,908	**9,008**
Total	**271,524**	**123,853**	**46,683**

* Severely disabled adults, unable to provide for basic self-care. DMH estimates approximately half will seek or use public mental health services at any given time (the target population). Despite long waiting lists for high demand or high intensity services such as case management, PACT and residential services, most adults who apply and meet the DMH eligibility criteria receive at least one less intensive community service while waiting. Alternatively, they are admitted, if they meet the clinical criteria, to DMH continuing care inpatient services.

An Unduplicated Count of Adult Clients Served by DMH in SFY'04

DMH Area	Case Management	Inpatient*	Resid/Rehab/Option
Metro Boston	1,487	536	1,997
North East	2,480	389	1,080
Southeastern	2,018	808	969
Metro Suburban	1,563	442	1,085
Central Mass.	1,215	229	708
Western Mass.	1,617	183	1,136
Total	**10,380**	**2,587**	**6,975**

* includes forensic and non-forensic admissions to all state hospitals, CMHCs and DMH units in public health hospitals, and one contracted unit as well as contracted forensic beds in the Western Mass. Area.

An Unduplicated Count of Elders (>65 years old) Served by DMH in SFY'04

DMH Area	Case Management	Inpatient*	Resid/Rehab/Option
Metro Boston	55	15	99
North East	68	6	32
Southeastern	94	24	25
Metro Suburban	53	19	25
Central Mass.	45	10	20
Western Mass.	95	3	78
Total	**410**	**77**	**286**

* includes forensic and non-forensic admissions to all state hospitals, CMHCs and DMH units in public health hospitals, and one contracted unit as well as contracted forensic beds in the Western Mass. Area.

As noted elsewhere, DMH provides primarily extended stay inpatient and continuing care community services, but very little acute care. For example, in **SFY'03**, MBHP (DMA's behavioral managed care vendor) provided mental health services for ***82, 590*** adults, some of whom may have met the criteria for serious mental illness.

Goal II/2 A: Implement a comprehensive, responsive and integrated mental health information system (MHIS).

Population: **Adults with serious mental illness**

Objective II/2-A: Implement Phase I, Phase II and Phase III of MHIS.

Brief Name: *Mental Health Information System*

Indicator: progress toward implementation of an integrated mental health information system (MHIS)

Year 3: Phased implementation of Phase II and Phase III continues and all required automated data for the block grant are derived from MHIS.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/2. *Mental Health Information System*					
Value: Implementation of mental health information system	**Phase I completed; Phases II & III pilots begun**	**Phases II & III underway**	**Phases II & III implementation underway; automated data available for BG reporting**	**Phases II & III implementation on target; automated data available for BG reporting**	**!00%**

SFY'04 Accomplishments: DMH is in the final stages of implementing its new Mental Health Information System (MHIS). MHIS will enable DMH to standardize data collection across the state. The ability to capture information about all of the services received by a DMH client will be greatly enhanced once it is fully operational. MHIS also is expected to reduce or eliminate many redundant steps now required to feed data into the various systems.

The project has been approached in three phases and when finished will provide the organization with an electronic client medical record accessible (with appropriate security) statewide. The complete implementation also is key to meeting other requirements, such as HIPAA (Health Insurance Portability and Accountability Act) and Uniform Data Reporting. The first phase of MHIS implementation (billing and other business systems) has been implemented and is operative in all of the Department's inpatient facilities. At the end of SFY'04, Phase II (community/care management) was installed and operating in five of the six DMH Areas and Phase III (inpatient electronic medical record) was installed and operating in all of the DMH hospitals and several of the CMHCs with inpatient units. Implementation of both will be completed in SFY'05 on a planned timetable. It is expected that once MHIS is fully operational, it will improve client care and also generate reports that enable managers to gauge program effectiveness. **Accomplished.**

CRITERION II - CHILD/ADOLESCENT PERFORMANCE INDICATORS

Goal II/1 C-A: Increase access to community-based mental health services

Population: **Children and adolescents with serious emotional disturbance**

Objective II/1 C-A: Increase the number of DMH clients who receive continuing care community services.

Brief Name: *Access to community-based services*

Indicator: **the percentage of children and adolescents who receive a continuing care community mental health service each fiscal year**

Measure: # of children who receive a DMH continuing care community service prevalence estimate of children with serious emotional disturbance

Year 3: Maintain the number of children and adolescents with SED who receive at least one DMH continuing care community service.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
II/1. *Access to Community Based Services*					
Value: % of children and adolescents receiving case management and/or residential and/or other community based services from DMH	**2.8%**	**2.8%%**	**2.8%**	**2.8%**	**100%**
Denominator: prevalence of SED	**111,692**	**111,692**	**111,692**	**111,692**	

* Please note that in Massachusetts, the Department of Public Health is specifically mandated to provide services for children birth to three years old. As noted in this report, DMH is only one of a number of child-serving agencies in the state, including local education authorities and private insurance, that provide children and adolescents with mental health services.

SFY'04 Accomplishments: In SFY'01, *3,137* (2.7%) DMH child and adolescent clients (an unduplicated number) received case management, residential (Rehab Option-billable) or another community service from DMH, insofar as the DMH Client Tracking System (CTS) was able to measure. Data from the new Mental Health Information System (MHIS) reported that *3,174* (2.8%) children and adolescents received these services in SFY'04. The number does not include inpatient services, outpatient services, forensic evaluation services or children receiving services on a short-term basis without an eligibility determination. The number also does not include children participating in

the interagency pilot projects (WCC and MHSPY) or the 4,000 families who receive help through parent support contracts. When the rate of those receiving services is calculated using *eligibility* as the denominator, then *88.8%* of eligible clients received at least one DMH community service.

It should be noted that the denominator (prevalence) is an estimate of the number of children in the state in need of mental health services. Any of several child-serving agencies (DSS, DYS, DMH and/or LEAs) as well as public or private insurance may serve this population. The numerator represents only the children for whom DMH provides continuing care community services. As noted elsewhere, DMH provides selected mental health services to a relatively small group of children and adolescents.

The enrolled population ("DMH client") refers to those individuals who have been determined to be eligible for DMH continuing care community services, for whom no other options, outside of DMH, exist. After being found eligible to receive DMH community services, each individual is assigned to services according to priority of need. If no appropriate community service is available, the individual is placed on a waiting list and is contacted on a regular basis regarding wait status. Also, DMH may authorize up to 60 business days of Flexible Support and/or day services prior to or without determining eligibility in the following circumstances: 1) while the need for DMH continuing care services is being assessed, 2) an eligibility application is pending, 3) in response to a referral from a juvenile court, 4) in accord with local interagency agreements, or 5) when the service is provided as a transitional intervention. **Accomplished.**

Through its Division of Forensic Mental Health Services, DMH provided a total of *3,411* evaluations to *2,535* children and adolescents the 11 Divisions of the Juvenile Court in 45 locations. Of these, *35%* were delinquency cases *(1,212)*; *26%* involved Children in Need of Supervision (CHINS) cases (897); *4%* were Care and Protection cases (131); and *>1%* involved civil commitment for mental illness or substance abuse (8). Upon request, DMH has conducted post-mortem peer reviews for Division of Youth Services staff after a suicide or other adverse event in its system.

Prevalence and the DMH Target Population

In 2000, based on publication of a final estimation methodology by the Center for Mental Health Services in July 1998, DMH adjusted its estimate for children 9-18. This was updated in August 2002 using 2000 census data. As noted previously, DMH continues to depart from the federal definition and consider children from 0 through 18 as its child/adolescent population. This has been the operative age definition in Massachusetts since 1988.

Based on Massachusetts' ranking in the middle tier of states in terms of number of children living in poverty, it is estimated that *seven* percent (children with serious emotional disturbance [SED] and *extreme* dysfunction) would need intensive mental health services. It is estimated that *eleven* percent (children with SED and *substantial* functional impairment) would meet DMH clinical eligibility criteria for less intensive community mental health services.

Researchers from UMass explored which, if any, variables particular to children and to Massachusetts could be used to weight the six DMH Areas in estimating prevalence. Based on available data and research, they determined the only reliable variable is poverty. The results of their work will continue to be used as a basis for distributing new budgetary resources for children and adolescents and are the basis for the prevalence data in the chart below. The chart includes the number of children in the DMH planning

population, by Area. Since there are no current nationally accepted data available to estimate prevalence among children 0-8, DMH will continue to estimate that *2.5 percent* of severely disabled children in that cohort will need mental health services. In Massachusetts, DMH, DMA, other child-serving state agencies, local education authorities and/or private insurance fund mental health services.

Prevalence Estimates for Children & Adolescents (2000 census data)

DMH Area	Total Population 0-18	Total Population 0-8	Total Population 9-18	SED 9-18 with extreme dysfunction (7%)	SED 9-18 with substantial functional impairment (11%)	SED 0-8 in need of mental health services (2.5%)
Western	**213,153**	**92,336**	**120,817**	**8,457**	**13,290**	**2,308**
Central	**215,692**	**100,996**	**114,696**	**8,029**	**12,617**	**2,525**
North East	**327,824**	**155,984**	**171,840**	**12,029**	**18,902**	**3,900**
Metro Boston	**189,510**	**87,821**	**101,689**	**7,118**	**11,186**	**2,196**
Metro Suburban	**320,811**	**154,976**	**165,835**	**11,608**	**18,242**	**3,874**
South-eastern	**275,059**	**145,719**	**172,815**	**12,097**	**19,010**	**3,643**
Total	**1,585,524**	**737,832**	**847,692**	**59,338**	**93,246**	**18,446**

The total planning population of children and adolescents in Massachusetts (the sum of the last two columns) is *111,692*.

An Unduplicated Count of Child/Adolescent Clients Served by DMH in SFY'04

DMH Area	Case Management	Inpatient*	Residential**
Metro Boston	202	18	104
North East	447	28	157
Southeastern	439	36	54
Metro Suburban	217	12	126
Central Mass.	243	9	59
Western Mass.	385	13	329
Total	**1,933**	**116**	**829**

* Includes forensic and non-forensic admissions to the three statewide contracted extended stay adolescent units at Westborough and Taunton State Hospitals and one DMH-operated statewide extended stay latency age unit

**Includes community residences and intensive residential treatment programs certified for Rehab Option and Psych Under 21 reimbursement

The figures in the chart represent only a small number of the children served by DMH and an even smaller portion of children receiving publicly funded mental health services in Massachusetts. For example, DMH provided residential services to an additional *125* children (non Rehab Option) categories not captured in the chart. DMH also provides community services in addition to case management and residential services. In addition, as noted elsewhere, the responsibility for providing mental health services to children and adolescents with serious emotional disturbance (SED) is shared among many Massachusetts agencies and the private sector. For example, in **SFY'03**, MBHP (DMA's behavioral managed care vendor) provided mental health services for ***44,560*** children, some of whom may have met the criteria for serious emotional disturbance.

Goal II/2 C-A: Implement a comprehensive, responsive and integrated mental health information system (MHIS).

Population: **Children and adolescents with serious emotional disturbance**

Objective II/2 C-A: Implement Phase I, Phase II and Phase III of MHIS.

Brief Name: *Mental Health Information System*

Indicator: progress toward the implementation of a mental health information system (MHIS)

Year 3: Phased implementation of Phase II and Phase III continues and all required automated data for the block grant are derived from MHIS.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
I/2. *Mental Health Information System*					
Value: Implementation of mental health information system	**Phase I completed; Phases II & III pilots begun**	**Phases II & III underway**	**Phases II & III implementation underway; automated data available for BG reporting**	**Phases II & III implementation on target; data available for BG reporting**	**100%**

SFY'04 Accomplishments: DMH is in the final stages of implementing its new Mental Health Information System (MHIS). MHIS will enable DMH to standardize data collection across the state. The ability to capture information about all of the services received by a DMH client will be greatly enhanced once it is fully operational. MHIS also is expected to reduce or eliminate many redundant steps now required to feed data into the various systems.

The project has been approached in three phases and when finished will provide the organization with an electronic client medical record accessible (with appropriate security) statewide. The complete implementation also is key to meeting other requirements, such as HIPAA (Health Insurance Portability and Accountability Act) and Uniform Data Reporting. The first phase of MHIS implementation (billing and other business systems) has been implemented and is operative in all of the Department's inpatient facilities. At the end of SFY'04, Phase II (community/care management) was installed and operating in five of the six DMH Areas and Phase III (inpatient electronic medical record) was installed and operating in all of the DMH hospitals and several of the CMHCs with inpatient units. Implementation of both will be completed in SFY'05 on a planned timetable. It is expected that once MHIS is fully operational, it will improve client care and also generate reports that enable managers to gauge program effectiveness. **Accomplished.**

CRITERION II - ADULT PERFORMANCE INDICATOR TABLE
Mental Health System Data Epidemiology

2004 Implementation Report

Population: Adults with Serious Mental Illness

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
II/1. *Access to community-based services*				
Value: % of clients receiving case management and/or residential and/or community rehab support services from DMH	**47.7%**	**43.5%**	**46.5%**	**39.8%**
Denominator: prevalence of SMI	**46,683**	**46,683**	**46,683**	**46,683**
2. *Mental Health Information System*				
Value: Implementation of mental health information system	**Phase I completed; Phases II & III pilots begun**	**Phases II & III underway**	**Phases II & III implementation underway; automated data available for BG reporting**	**Phases II & III implementation on target; automated data available for BG reporting**

CRITERION II - C/A PERFORMANCE INDICATOR TABLE
Mental Health System Data Epidemiology

2004 Implementation Report

Population: Children & Adolescents with Serious Emotional Disturbance

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
1. *Access to community-based services*				
Value: # of children and adolescents receiving case management and/or residential and/or other community-based services from DMH	**2.8%***	**2.8%***	**2.8%***	**2.8%***
Denominator: prevalence of SED	**111,692****	**111,692****	**111,692****	**111,692****
2. *Mental Health Information System*				
Value: Implementation of mental health information system	**Phase I completed; Phases II & III pilots begun**	**Phases II & III underway**	**Phases II & III implementation underway; automated data available for BG reporting**	**Phases II & III implementation on target; automated data available for BG reporting**

* Please note that in Massachusetts, the Department of Public Health is specifically mandated to provide services for children birth to three years old. As noted in this report, DMH is only one of a number of child-serving agencies in the state, including local education authorities, that provide children and adolescents with mental health services.
** Prevalence estimate based on 2000 census data.

CRITERION III: CHILD/ADOLESCENT PERFORMANCE INDICATORS

Children's Services

Goal III/1 C-A: Provide necessary services to maintain children and adolescents in the community and prevent out-of-home placements through provision of coordinated care

Population: Children and adolescents with serious emotional disturbance

Objective III/1 C-A: Provide coordinated care to children whose needs require interventions under the jurisdiction of more than one child-serving agency

1(a) Brief Name: *Collaborative Assessment Program*

Indicator: **the percentage of children and adolescents served for whom out-of-home placement is avoided**

Measure: # of children & adolescents served by the CAP who are still living at home at the six month follow-up in each fiscal year
# of children & adolescents served by CAP in each fiscal year

Year 3: Increase or maintain the number of children and adolescents served by the CAP program still living at home at the six-month follow-up

Performance Measures:	SFY'02 Actual	SFY'03 Actual	SFY'04 Goal	SFY'04 Actual	% Attained
III/1(a). C*ollaborative Assessment Program*					
Value: % of children and adolescents served for whom out-of-home placement is avoided	**65.4%**	**69%**	**67%**	**70%**	**Exceeded 100%**
Denominator:	**214**	**223**	**N/A**	**204**	

SFY'04 Accomplishments: Collaborative Assessment Program (CAP) is a statewide DMH/DSS program that addresses children and adolescents at risk of out-of-home placement. CAP provides comprehensive assessments, flexible, short-term interventions to meet the needs of children and families in the least restrictive way, linkage to other parents for support and advocacy, and linkage to community resources. CAP aims to maintain children in their natural environment, unless contraindicated. After the assessment period, CAP identifies the local resources and/or state agencies (DSS or DMH) that need to be involved to maintain the child in the community, and the services that will best address the child and family's needs.

During SFY'04, *232* children statewide were assessed as part of the CAP. Six-month follow-up visits were completed on *204* children, and *143,* or *70 percent,* were living at home at the time of the visit. Following the procedure used to establish the baseline, the six-month follow-up for children who entered the program less than six months before the end of SFY'04 will be reported in SFY'05. **Accomplished**.

1(b) Brief Name: *Interagency care coordination*

Indicator: the number of children and adolescents receiving interagency care coordination

Measure: # of children & adolescents enrolled in the MHSPY and WCC programs in each fiscal year
# of children & adolescents enrolled in the MHSPY & WCC programs in SFY'01

Year 3: Maintain the number of children and adolescents receiving interagency care coordination in WCC and MHSPY

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
III/1(b). *Interagency Care Coordination*					
Value: # of children and adolescents receiving interagency care coordination	**152**	**153**	**160**	**176**	**Exceeded 100%**
Denominator: '01 baseline	**90**	**90**	**90**	**90**	

SFY'04 Accomplishments: Mental Health Service Program for Youth (MHSPY) and Worcester Communities of Care (WCC) are interagency projects aimed at keeping children in their communities through provision of intensive wraparound services and clinical care coordination. Each project has an interagency steering committee and uses blended funding to achieve its goals.

MHSPY is a state-funded program that was established to serve children who are Medicaid clients from the communities of Cambridge and Somerville and enrolled in the Neighborhood Health Plan HMO. The original program has expanded to include three additional sites in Malden, Medford and Everett.

WCC, funded through a Child Mental Health Initiative grant from the federal Center for Mental Health Services and local matching funds, serves Medicaid and non-Medicaid families of children at risk of out-of-home placement in the city of Worcester. Due to continuing budget uncertainties and concerns about future funding in both programs, the original goal was amended in the State Plan. However, resolution of state match and federal funding issues enabled WCC to significantly expand enrollment in June.

In SFY'04, MHSPY served *94* children. In SFY'04, WCC served *82* children. **Accomplished.**

Goal III/2 C-A: Change the culture and improve staff-client interaction in DMH-licensed and contracted programs and facilities to reduce violence and the need for mechanical and chemical restraint

Population: Children and adolescents with serious emotional disturbance

Objective III/2 C-A: Reduce incidents of restraint and seclusion in child-adolescent treatment settings

Brief Name: *Reducing Violence*

Indicator: the number of incidents of restraint in inpatient facilities and all intensive residential treatment programs in each fiscal year

Measure: # of reported incidents of restraint in DMH-licensed and contracted inpatient facilities and all intensive residential treatment programs
# of reported incidents of restraint in DMH-contracted inpatient facilities and all intensive residential treatment programs in fiscal year '01

Year 3: Reduce the use of restraint by *25%* (over SFY'01), as reported to DMH

Performance Measures:	**SFY'01 Actual**	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Actual**	**% Attained**
III/2. *Reducing Violence*					
Value: % reduction in reported incidents of restraint in inpatient & intensive residential treatment programs	**Baseline data '01**	**Developed curricu-lum; provided consulta-tion & technical assistance**	**10% goal exceeded in all categories**	**Goal =25% reduction in all categories (over '01)**	
# episodes per 1,000 patient days					
DMH-licensed hospitals					
Children	**87.22**		**27.79**	**30.72**	**Exceeded**
Adolescents	**66.17**		**42.71**	**36.27**	**Exceeded**
Mixed C/A	**80.71**		**16.14**	**21.91**	**Exceeded**
DMH-contracted inpatient					
Children*	**157.63**		**N/A***	**N/A***	**N/A***
Adolescents	**64.93**		**41.38**	**97.26**	**Not met**
DMH-contracted IRTPs					
Children	**119.94**		**62.92**	**47.36**	**Exceeded**
Adolescents	**51.30**		**23.97**	**29.07**	**Exceeded**

* this contract was terminated at the end of SFY'02 and a state-operated unit to serve the same population was opened in July 2002 at the Erich Lindemann Mental Health Center in Boston. It remained in operation for one year only.

SFY'04 Accomplishments: DMH collects statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient units and IRTPs. Through its

licensing and contracting authority, DMH provides direction, technical assistance and clinical expertise and consultation on state-of-the-art practices designed to reduce the utilization of these high-risk interventions. Review of each unit's restraint data and a discussion of prevention, early intervention and pro-active planning efforts have been a focus of each two-year licensing visit and monthly contract monitoring. When analysis of trend data indicated a rise in the number of R/S incidents, DMH embarked on an initiative to substantially reduce and eventually eliminate the use of R/S in these units and programs. Baseline data for comparative purposes was established in October 2000. Licensing and child/adolescent division staff visited programs in other states, and in SFY'02, designed and implemented a curriculum, with the assistance of a nationally recognized expert in the field, to provide technical assistance to the DMH-licensed and contracted inpatient units and intensive residential treatment programs for children and adolescents. The goal was to help them change the culture of violence and reduce the need for use of restraint and seclusion. Since SFY'02, DMH has held a series of statewide conferences, site visits, and grand rounds and required each unit and program to develop its own strategic plan to reduce the use of R/S.

In SFY'04, the Center for Medicare and Medicaid (CMS) changed the definition of restraint to include *any* physical hold. Thus, although the SFY'04 reported incidents of restraint are, in some categories, higher than SFY'03, the data from these two years are not based on the same definition. It will take a while to educate all the providers about the new rules in order to report consistent and comparable data. Nevertheless, the number of reported incidents has declined significantly. **Partially accomplished**.

CRITERION III – C/A PERFORMANCE INDICATOR TABLE
Children's Services

2004 Implementation Report

Population: Children with serious emotional disturbance

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
III/1(a). *Collaborative Assessment Program*				
Value: % of families served by CAP for whom out-of-home placement is avoided at 6-month follow-up	**65.4%**	**69%**	**67%**	**70%**
Denominator:	**214**	**223**	**N/A**	**204**
III/1(b). *Interagency care coordination*				
Value: # of children who receive interagency care coordination enrolled in MSPY and WCC projects	**152**	**153**	**160**	**157**
Denominator:	**90**	**90**	**90**	
III/2. *Reducing Violence*				
Value: the % reduction of reported incidents of restraint in inpatient & intensive residential treatment programs	**Developed curriculum; provided consultation and TA**	**Exceeded 10% goal in all categories**	**25%**	**Exceeded in all but one category**

CRITERION IV: ADULT PERFORMANCE INDICATORS

Targeted Services to Rural and Homeless Populations

Goal IV/1 A: Provide housing and employment options, and residential services, for individuals with serious mental illness who are homeless

Population: **Adults with serious mental illness**

Objective IV/1 A: Increase the number of homeless individuals with mental illness that receive residential services

Brief Name: *Residential services for homeless DMH clients*

Indicator: **the number of new homeless DMH clients receiving residential services each fiscal year**

Measure: # of new homeless DMH clients receiving residential services each year

Year 3: Maintain the rate of service to new homeless DMH clients in need of residential services

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
IV/1. *Residential Services for DMH Clients*					
Value: # of new HMI DMH clients receiving residential services	**477**	**511**	**508**	**510**	**Exceeded 100%**

Objective IV/2 A: Increase the number of homeless DMH clients working competitively

Brief Name: *Employment services for homeless DMH clients*

Indicator: **the number of homeless DMH clients working competitively**

Measure: # of homeless DMH clients working competitively each year
# of homeless DMH clients working competitively in SFY'01

Year 3: Increase the number of homeless DMH working competitively by *30*

Performance Measures:	SFY'02 Actual	SFY'03 Actual	SFY'04 Goal	SFY'04 Actual	% Attained
IV/2. *Employment Services for Homeless DMH Clients*					
Value: # of homeless DMH clients working competitively	**29**	**41**	**49**	**48**	**98%**
Denominator: '01 baseline	**19**	**19**	**19**	**19**	

SFY'04 Accomplishments:

DMH has been committed to a number of major goals and action steps for enhancing services to chronically homeless persons, particularly those with serious mental illness and co-occurring substance abuse disorders. These goals and action steps have been part of DMH's work with the Massachusetts Interagency Council on Homelessness and Housing created by Governor Mitt Romney, and chaired by Lt. Governor Kerry Healey. DMH is an active member of the Council.

Additionally, because chronically homeless persons constitute a critical sub-category of the Commonwealth's homeless population, DMH and the Department of Transitional Assistance (DTA) convened an Interagency Work Group on Chronically Homeless Persons in 2004. Co-chaired by DTA Commissioner John Wagner and DMH Commissioner Elizabeth Childs, M.D., the workgroup has been meeting monthly as a sub-committee of the Interagency Council.

The DTA-DMH workgroup is being guided in its efforts by *Massachusetts' Ten-Year State Plan to End Chronic Homelessness,* as prepared by the Massachusetts Policy Academy on Chronic Homelessness and adopted by the Council in 2004. DTA and DMH continue to co-chair the state's Policy Academy and Plan process, which involves other state agencies and the Massachusetts Housing and Shelter Alliance. The Policy Academy effort is a formal, ongoing national dialogue between states and federal agencies with homelessness-related responsibilities.

In order to enhance and expand this work, and also to further the work of the Interagency Council on Homelessness and Housing, DMH took the specific action steps outlined below in SFY'04. Areas of focus included:

- Promoting the development of extremely low-income affordable housing through existing state and federal housing programs;
- Advocating for and otherwise facilitating the development of housing on state hospital surplus property;
- Supporting housing models using state-appropriated shelter funds;
- Enhancing early warning homeless prevention systems as well as discharge planning protocols;
- Increasing interagency collaboration on complex homeless cases;
- Improving interagency data coordination; and,
- Creating employment service options for homeless persons.

IV/1/1: DMH Homeless Initiative (HI) dollars are used primarily to provide clinical and residential services and to leverage other resources to fund development or access to housing units. Success of the efforts depends on continued collaboration with

advocates, other state and federal agencies and legislative appropriation. SFY'02 was the first year in many that DMH did not receive an increase in the legislative appropriation for its Homeless Initiative. There was no increase in SFY'03 or SFY'04 either. The initial funding recommendation in the state's FY'04 budget included a reduction of $1.5 million for this program, but the money was eventually restored. Therefore, DMH has adopted a "maintenance of effort" approach concerning placement of homeless individuals.

Although there were no new HI funds appropriated for SFY'04, the placement target was exceeded. This occurred through the increased enrollment of homeless individuals in several DMH programs, including the Homeless Initiative, PACT teams and residential services. The total number of new homeless clients receiving residential services in SFY'04 was *510*. It is important to note that this was not a gain of new services or housing slots, but new clients entering existing as well as new services or housing arrangements. The existing beds became available as incumbent occupants moved on to other arrangements. **Accomplished.**

Other programs for homeless individuals with mental illness include PATH, which provided outreach and screening services to *5,000* people, with *3,700* enrolled; and housing efforts funded through the DMH Facilities Consolidation Fund.

The Aggressive Treatment and Relapse Prevention program (ATARP) completed its sixth year of operation in SFY'04. This permanent housing program serves homeless individuals and families diagnosed with co-occurring substance abuse and psychiatric disorders. ATARP served a total of *64* single adults, *8* adults in families and *9* children, and remained at or near capacity throughout the year. In SFY'04, the five contracted service providers reported that *35%* of participants remained in their housing for more than four years, *48%* for three or more years and *56%* for two or more years. Improved stability also was reported in the number of participants who remained abstinent from alcohol and illegal drugs (*58%*). Further, over half of all participants (*52%*) secured employment or training (minimum of 120 hrs.) during the reporting year. These results point to the continued success of this program in serving a very complex and compromised population that responds well to having their own housing within an environment that promotes recovery and manages relapse.

In January 2004, DMH and DPH hosted a statewide ATARP conference, bringing together over 70 participants that included professionals from the mental health and addictions fields. The conference included presentations by the five ATARP providers, as well as personal stories of participants and reflections by experts in the field on the efficacy of the program.

The Aggressive Street Outreach program operates in multiple locations in the state (Boston, Lowell, Lawrence, North Shore, Waltham, Framingham and surrounding areas) in partnership with the PATH program and is managed by Tri-City Mental Heath. The program is targeted to serve *300* homeless individuals living in alleys, abandoned buildings, under bridges, parks and other at-risk locations. The program reports that over one quarter of the clients (*27%*) were placed in permanent or transitional housing during the year, and of these, close to one half (*42%*) remained in their housing six months or more. Staff were able to secure benefits for *72%* of clients referred for public benefits. With respect to accessing services, *85%* of those seeking detoxification were able to access a bed, and *50%* of those in need of mental health services accepted them.

IV/1/2: "Employment Connections" (the competitive employment program for homeless individuals) is a joint initiative with the Department of Employment and

Training. Employment services for homeless people also are provided in DMH-funded Community Support Clubhouses and Services for Education and Employment (SEE) programs. Since its inception, through SFY'04, the Employment Connections program has provided job services to *an average of 75-90* consumers per year. In SFY'04, *72* DMH clients received services, with *48* of them working during the fiscal year. Average wages for clients placed in competitive employment ranged from $7.00 to $26.83 an hour, with an average wage of $13.77 an hour. **Accomplished.**

CRITERION IV: CHILD AND ADOLESCENT PERFORMANCE INDICATORS

Targeted Services to Rural and Homeless Populations

Goal IV/1 C-A: Provide residential, educational and vocational support services to youth aging out of the state's child serving agencies

Population: Transition-age adolescents with serious emotional disturbance at-risk of becoming homeless

Objective IV/1 C-A: Establish a new program of supported educational and vocational services for transition-age adolescents

Brief Name: *Supported educational and vocational services*

Indicator: the number of transition-age adolescents receiving supported educational and vocational services each fiscal year

Year 3: Maintain the number of transition-age adolescents receiving supported educational and vocational services.

Performance Measures:	SFY'02 Actual	SFY'03 Actual	SFY'04 Goal	SFY'04 Actual	% Attained
IV/1. *Supported Educational and Vocational Services*					
Value: # of transition-age adolescents receiving supported educational and vocational services	**30**	**30**	**30**	**48**	**Exceeded 100%**

SFY'04 Accomplishments: There are many adolescents who have received services from DMH and/or other child-serving state agencies whose emotional disturbance has prevented them from developing the skills necessary to make a transition to independent living. They lack the skills and supports that young people need to live in the community, either with their families or independently. Because many of these youngsters do not meet the clinical criteria for receiving adult services in the DMH system, they are at risk for falling through the cracks and becoming homeless. DMH has tried to address the particular needs of this transitional population. Currently, there is one very successful program in the Metro Suburban Area that provides educational and employment services to a group of transitional age youth. The program served *48* adolescents during SFY'04. In addition, several other DMH Areas have designated case managers to serve the transition age population and the North East Area has initiated a peer mentoring program to focus on housing and employment needs. Every effort is made to link these adolescents with appropriate community agencies. **Accomplished.**

CRITERION IV - ADULT PERFORMANCE INDICATOR TABLE
Rural and Homeless Populations

2004 Implementation Report

Population: Adults with Serious Mental Illness

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
IV/1. *HMI residential services*				
Value: # of new HMI DMH clients receiving residential services each year	**477**	**511**	**508**	**510**
IV/2. *HMI employment services*				
Value: # of *new* clients working competitively each year	**29**	**41**	**49**	**48**
Denominator: '01 baseline	**19**	**19**	**19**	

CRITERION IV - C/A PERFORMANCE INDICATOR TABLE
Rural and Homeless Populations

2004 Implementation Report

Population: Children and Adolescents with Serious Emotional Disturbance

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
IV/1. *Supported Educational & Vocational Services*				
Value: # of youth receiving educational and vocational support services	**30**	**30**	**30**	**48`**

CRITERION V: ADULT PERFORMANCE INDICATORS

Management Systems

This criterion has a single narrative of issues common to adults and children. The goals and performance measures are age-specific. (Please refer to child/adolescent performance indicator table on page 80.)

Goal V/1 A: Provide funds for community-based services

Population: **Adults with serious mental illness**

Objective V/1 A: Increase community services budget.

Brief Name: *Fiscal resources for community-based services*

Indicator: the percentage of total budget expended for community-based services

Measure: Adult community program funds
Total DMH direct services budget

Year 3: 58.3% of the total DMH budget is allocated for community-based services.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
IV/1. *Fiscal Resources*					
Value: % of total direct services budget expended for adult community services	**55%**	**58%**	**58.3%**	**59.7%**	**Exceeded 100%**
Denominator:	**$594.8 m**	**$582 m**	**$557.8 m**	**$573.8 m**	

SFY'04 Accomplishments: The Department of Mental Health is mandated to target its services to the most seriously mentally ill adults, children and adolescents in the Commonwealth through an array of services providing treatment, support and structured skills development. This array of services includes inpatient as well as case management, day/vocational, residential, outpatient and educational, peer and family support services. The goal of the service delivery system is to assist DMH clients to achieve and maintain the highest possible level of functioning so they may live, work and attend school in the communities of their choice.

The conceptual framework recognizes that the mental health needs of individuals are unique and change over time. In order to respond to these changing needs, the service system must be flexible and offer treatment for symptoms of mental illness and serious emotional disturbance, as well as rehabilitation and supportive services to assist each

individual in coping with the functional disabilities resulting from his/her illness. DMH also recognizes the need to work with families and the community at large to provide a supportive environment.

The SFY'04 available state appropriation was *$592.8* million. When federal, trust and capital funds are added to the state appropriation, the total amount available was *$630.9* million, with *66.24 percent* committed to community-based care. The SFY'04 available state funding for direct services was *$573.8* million (down $8.2 million from the previous fiscal year), of which *13.12%* (*$75.3* million) was specifically earmarked for child and adolescent community services, 59.7*%* ($342.7 million) for adult community services, and *$155.9* million for adult and child/adolescent inpatient services (in state hospitals, including three contracted adolescent units, state-operated community mental health centers and one adult contracted extended stay private hospital unit).

DMH clients receive services from state-operated and/or vendor-run programs. The majority of the state-operated programs provide extended stay inpatient services in state facilities, although inpatient care accounts for only *26.3 percent* of the total state appropriation. Most community and some inpatient services are provided through contracts with providers. In SFY'04, there were *405* contracts for adult services (@$275.4 million), *173* for child and adolescent services (@$74.3 million) and *27* for mixed (generic adult/child) services (@$9.9 million).

Revenue generation is a significant factor in supporting the Department's budget. Since 1988, DMH has significantly increased the amount of revenue it generates from its state hospitals, CMHCs and intensive residential treatment programs, as well as from Medicaid Rehab Option and case management services for DMH Medicaid-eligible clients. Revenue in SFY'04 was *$140.5* million, compared with *$8.7* million in SFY'88. With the exception of revenue from the CMHCs, which is retained by DMH in statutorily created trust funds under the Department's control, and a small retained revenue account for occupancy fees, all other revenue goes to the General Fund (state treasury). However, since the Department's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting the Department's budget.

Human Resources

At the end of SFY'04, DMH directly employed *3,871* FTEs, and continued to work with state-operated facilities as well as vendor-run programs to increase the availability of qualified, culturally diverse staff. Primarily, vendors under contract to DMH provide community services to DMH clients. DMH had to curtail its training agenda for state and vendor staff again in SFY'04 due to budget reductions.

Private human service agencies have continued to experience difficulty recruiting and retaining qualified workers, especially direct care line staff. Paradoxically, this has not improved as the economy has worsened. The erosion in base funding for state contracts has further exacerbated the problem. DMH has historically supported a line item in the state budget to increase the salaries of the lowest paid direct service workers in vendor-run programs. There was a modest amount included in the SFY'04 budget for this purpose. In the current, precarious budget climate, however, this solution is unlikely to remedy the staffing dilemma. An EOHHS-led review of the "purchase of service" system is underway to maximize purchasing efficiencies thereby freeing service dollars.

Recruitment and retention of nurses continues to be difficult for private providers and the state hospitals. This is consistent with problems other states are facing.

At the end of SFY'04, DMH had *426* case manager positions. This includes adult and child/adolescent case managers as well as eligibility determination specialists and reflects reductions that occurred from early retirement and unfilled vacancies.

An analysis of staff-to-patient ratios for DMH inpatient facilities and hospitals, coupled with a revised classification system for inpatient populations, has allowed DMH to assess staffing patterns and manpower needs within its facilities across the state.

DMH participated in a statewide position classification and essential functions study. The results will support ADA requirements and update generic job specifications for all titles and career ladders within the Commonwealth.

Training

In-service training for all staff continues at the local level, including annual statewide training on HIV/AIDS and Infection Control, on new DMH policies as needed, on Disaster Training, and on Elder Mental Health Issues. Trainings for case managers, on topics identified by the Area training directors, are held each year, linked to a pay incentive. Mandatory training concerning sexual harassment is provided for all staff. DMH also provides difficult-to-treat and psychopharmacology case consultations, as requested, but has had to eliminate its statewide Speakers Bureau for DMH and vendor staff. Although the statewide conferences on Human Rights, Adult and Child/Adolescent Clinical Services and Cultural Diversity were not reinstated in SFY'04 due to budget constraints, the DMH Areas continued to host conferences on topics as varied as cultural diversity, women's issues, health and wellness, elder mental health issues and ethics. DMH did sponsor one provider conference and three grand rounds to support its multi-year Restraint Reduction Initiative to reduce and eventually eliminate restraint and seclusion in child and adolescent inpatient units/facilities and intensive residential treatment programs. Providers (DMH-licensed child and adolescent inpatient units) hosted three peer-led roundtables, and also participated, with DMH, in the development of a restraint reduction manual that will be used in ongoing training activities.

DMH completed the first year of a new five-year contract with eight medical school-affiliated programs to train adult, child and forensic psychiatric residents and psychology interns and fellows and met on a regular basis with the training directors to ensure fidelity to the training concepts and curriculum expectations in the contract. The training directors also participated in the development of an instrument to survey client satisfaction with clinical care provided by the trainees, also as required by the contract.

DMH-funded research and clinical staff at the UMass Medical School Center for Mental Health Services Research provided training for the Genesis Clubhouse (Shrewsbury), Committee for Public Counsel Service (public defenders), Marlborough Fire Department, Massachusetts Criminal Justice Training Council, Southern Worcester County First Responder Training Academy, all clinicians in the Juvenile Court Clinics, Boston Police Academy, Massachusetts Veterans Shelter (Worcester), and Women's Community Corrections.

The DMH clinical practice guidelines for the treatment of schizophrenia and bipolar disorder, including "user-friendly" versions of both sets of guidelines for use by consumers and families, and Guidelines for Psychoactive Medications for Children and Adolescents, in English and Spanish, are posted on the DMH internal and external web sites.

Goal V/2 A: Ensure that DMH provides culturally competent services.

Population: **Adults with serious mental illness**

Objective V/2/1 A: Implement the Governor's Diversity Initiative

Brief Name: *Diversity Initiative*

Indicator: annual Governor's Diversity Initiative goals are implemented

Year 3: The Transitional Employment Program is maintained at existing levels. Retention programs are strengthened in an effort to enhance the workforce diversity profile.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
IV/1. *Diversity Initiative*					
Value: the Governor's diversity Initiative is implemented	Mid & high level management positions exceeded goal; employment opportunities for people with disabilities were created; staff language survey completed.	Diversity training was provided to all employees; steps were taken to ameliorate the impact of involuntary reductions on diversity of workforce	Transitional employment program is maintained; retention programs are strengthened	Supported employment positions for consumers were maintained	**100%**

Objective V/2/2 A: Implement the Department's Cultural Competency Action Plan

Brief Name: *Cultural Competency*

Indicator: annual goals in the DMH Cultural Competency Action Plan are implemented

Year 3: SFY'04 Plan goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Performance Measures:	SFY'02 Actual	SFY'03 Actual	SFY'04 Goal	SFY'04 Actual	% Attained
V/2/2. *Cultural Competency*					
Value: annual goals in DMH Cultural Competency Plan are implemented	**CCAP goals for SFY'02 were accom-plished**	**CCAP goals for SFY'03 were accom-plished**	**Accom-plish CCAP goals for SFY'04**	**SFY'04 CCAP goals are accom-plished**	**100%**

SFY'04 Accomplishments:

V/2/1: The employment model was changed from Transitional Employment to Supported Employment. The number of positions for consumers was maintained and these consumers now receive the same benefits as state employees. **Accomplished.**

V/2/2: In SFY'04, DMH implemented the third year of its three-year Cultural Competence Action Plan (CCAP). Over the course of implementing the three-year plan, 33 objectives were achieved. DMH carried out the following activities to meet the Plan's stated goals for the year: **Accomplished.**

Community Inclusion:

- The Latino Mental Health Planning Project in the DMH Central Mass. Area, funded by Blue Cross/Blue Shield Foundation of Massachusetts, was completed. Through outreach activities, the Area established an ongoing partnership with Latino consumers, their families, and with representatives of local community support systems and community-based agencies. It also conducted a culturally and linguistically appropriate assessment of health and mental health needs of 160 individuals and families.
- A proposal to the BC/BS Foundation to better meet the medical and psychiatric needs of Latinos in Worcester, based on the findings of the needs assessment, was submitted. The proposal includes a community training, education and outreach project to serve health and human service providers, consumers and their families in the Latino community. This project will coordinate activities aimed at reducing stigma, increasing health literacy, empowering consumers and families, and promoting culturally competent health and mental health services.

Human Resources:

- Director of OMCA participated on the EOHHS Diversity Team
- Completed the EOHHS Agencies Diversity Survey
- The Metro Boston Area and Roxbury Community College established a "Mental Health Worker Certificate" program. The purpose of this program is to improve the skills and competencies of current and future mental health workers. The curriculum has cultural competence as a major focus.

Services:

- Completed the Interpreter Services Handbook for DMH employees
- Updated DMH Translation Catalog; translated HIPAA documents into eight languages

Education and Training:

- Completed the Diversity-Cultural Competence training module and conducted five pilot trainings with DMH employees, including the DMH Area Training Directors.

Highlights of other training, presentations and community dialogues:

- The Next Generation in Cultural Competence: Strategic Planning and Measurement Strategies, Georgetown University Center for Child and Human Development Training Institute, National Technical Assistance Center for Children's Mental Health, San Francisco, CA.
- Practical Strategies for Reducing Racial/Ethnic Disparities within Systems of Care Communities, Technical Assistance Partnership for Child and Family Mental Health, Washington, D.C.
- New Young Americans: Charting a Course for Immigrant Youth in a Changing Commonwealth, Suffolk University Law School
- Cultural and Developmental Awareness, Parent/Professional Advocacy League, statewide training
- Integrating Culture into Practices, National Alliance for the Mentally Ill-Massachusetts, Parent Professional Advocacy League, Lilly Pharmaceutical
- Adolescent Development & Parenting Strategies, Massachusetts Asian American Educators Association
- Working with Children, Adolescents and Families of Culturally Diverse Background, Certified Juvenile Court Clinician Seminar Series, University of Massachusetts Medical School
- Integrating Client's Culture into Homeless Outreach Strategies, PATH Grant Homeless Outreach Workers, including family shelters, statewide
- Integrating Culture into Clinical Practice, University of Massachusetts Medical School & Harvard Medical School, Psychology Internship programs

Data and Research:

- Continued to fund the Boston University School of Medicine, Division of Psychiatry, to study the effect of Race and Lithium Level

Information:

- Established Cultural and Linguistic Competence Information and Resource Clearinghouse for DMH employees and community providers.

CRITERION V: CHILD/ADOLESCENT PERFORMANCE INDICATORS

Management Systems

Goal V/1 C-A: Provide funds for community-based services.

Population: **Children and adolescents with serious emotional disturbance**

Objective V/1 C-A: Increase community services budget.

Brief Name: *Fiscal resources for community-based services*

Indicator: Percentage of total budget expended for community-based services

Measure: Child/Adolescent community program funds
Total DMH direct services budget

Year 3: *11.66*% of the total DMH budget is allocated for community-based services.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
V/1. *Fiscal Resources for Community Services*					
Value: % of total direct services budget expended for C/A community services	**12.42%**	**12.67%**	**11.66%**	**13.12%**	**Exceeded 100%**
Denominator: direct services budget	**$594.8 m**	**$582 m**	**$557.8 m**	**$573.8 m**	

SFY'04 Accomplishments: See narrative on pages 63-65

Goal V/2 C-A: Ensure that DMH provides culturally competent services.

Population: **Children and adolescents with serious emotional disturbance**

Objective V/2/1 C-A: Implement the Governor's Diversity Initiative.

Brief Name: *Diversity Initiative*

Indicator: annual Governor's Diversity Initiative goals are implemented

Year 3: The Transitional Employment Program is maintained at existing levels. Retention programs are strengthened in an effort to enhance the workforce diversity profile.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
IV/2. *Diversity Initiative*					
Value: the Governor's Diversity Initiative is implemented	Mid & high level manage-ment positions exceeded goals; opportuni-ties were created for people with disabilities; staff language survey completed	Diversity training was provided to all employees; steps were taken to ameliorate the impact of involuntary reductions on diversity of workforce	Transitional employment program is maintained; retention programs are strengthened	Supported employ-ment positions for consumers were maintained	**100%**

Objective V/2/2 C-A: Implement the Department's Cultural Competency Action Plan.

Brief Name: *Cultural Competency*

Indicator: the DMH Cultural Competency Action Plan is implemented

Year 3: SFY'04 Plan goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**	**% Attained**
V/2/2. *Cultural Competency*					
Value: The DMH Cultural Competency Action Plan (CCAP) is implemented	**CCAP goals for SFY'02 were accom-plished**	**CCAP goals for SFY'03 were accom-plished**	**Accom-plish CCAP goals for SFY'04**	**CCAP goals for SFY'04 accom-plished**	**100%**

SFY'04 Accomplishments: See narrative on page 67-68

SPENDING REPORT

In accordance with Public Health Services Act Section 1917 (a), Part B, Title XIX, the Massachusetts Department of Mental Health is submitting this annual report of its activities under the mental health portion of the ADMS Block Grant. The attached analysis provides a description of state activities under the block grant and a summary of the purposes for which block grant funds were spent for the federal fiscal year 2002 award.

Summary of Programs and Funding

A. ALLOCATIONS

Table I is a summary of mental health block grant funding in Massachusetts. Funds awarded in a given federal fiscal year may be expended during more than one state fiscal year for two reasons. First, block grant funds are expended on the state fiscal year (SFY) cycle (July 1 to June 30) which differs from the federal fiscal year (FFY). Secondly, federal legislation for the period covering this grant requires a state to commit funds within the first year of the grant and spend the funds within two years of the grant award. Therefore, the following tables represent how FFY'02 block grant resources were expended over the SFY involved.

TABLE I/SUMMARY OF BLOCK GRANT FUNDING

APPLICATION	FED FY	STATE FY	AMOUNT
1	82	81-84	$9,266.044
2	83	84-85	$10,237,607
3	84	85-86	$10,106,839
4	85	86-87	$10,106,839
5	86	87	$10,106.839
6	87	87-88	$10,338,453
7	88	88-89	$10,106,839
8	89	89-90	$10,364,254
9	90	90-91	$9,609,228
10	91	91-93	$9,889,591
11	92	92-94	$9,889,591
12	93	93-95	$9,869,692
13	94	94-96	$6,434,900
14	95	95-97	$6,434,900
15	96	96-98	$6,364,827
16	97	97-99	$6,360,517
17	98	98-00	$6,360,517
18	99	99-01	$6,360,517
19	00-01	00-02	$8,443,383
20	02	01-03	$8,650,294
21	03	02-04	$8,502,548
22	04	03-05	$8,598,380

Table II shows the distribution of FFY'03 block grant funds by Area for the state in SFY'04. The six DMH Area offices are responsible for contract management, monitoring and quality assurance for block grant funded programs.

TABLE II/DISTRIBUTION OF BLOCK GRANT FUNDS BY AREA
SFY'03-05

WESTERN MASS	430,427
CENTRAL MASS	1,508,990
NORTH EAST	1,505,394
METRO BOSTON	901,978
METRO SUBURBAN	1,868,738
SOUTHEASTERN	1,383,199
STATEWIDE INITIATIVES	999,654
TOTAL	8,598,380

B. SERVICES FOR FFY'02 BLOCK GRANT

The block grant funds represent approximately *1.53%* of the SFY'04 total support for community mental health services. These funds are targeted to a range of community mental health programs for adults with long term or serious mentally illness, children and adolescents with severe emotional disturbance, and traditionally under served populations, such as cultural and linguistic minorities.

Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded services.

The Department of Mental Health is mandated to target service delivery to citizens of the Commonwealth with the most serious mental illness. The emphasis is on programs that maximize the independent functioning of these individuals through an array of services providing support and structured skills development. Services provided in the community are designed to decrease unnecessary hospitalization by providing sufficient support to enable individuals to be successfully maintained outside of inpatient settings.

The community service system array in the SFY'04 report reflects a commitment to provide continuing care services for DMH's clients.

The conceptual framework for mental health services recognizes that the mental health needs of individuals are unique and change over time. In order to respond to these changing needs, the service system must be flexible and offer treatment for symptoms of mental illness, as well as rehabilitation and supportive services to assist each individual in coping with the functional disabilities resulting from his/her illness.

The goal of the Massachusetts service delivery system is to assist DMH clients to achieve and maintain the highest possible level of functioning so that they may live and work in the communities of their choice. To reach this goal, a range of treatment and psychiatric rehabilitation services must be available. This range includes case management, day/vocational, residential, outpatient, and peer and family support services. **Table III** lists the program types the Department uses in developing a system of community services to respond to clients' needs.

The block grant provides an important means for the Department to develop a fully comprehensive service system. By supporting the development of new programs and services where needed, the block grant provides critical assistance to DMH in developing a system of community services. DMH uses the same competitive procurement mechanisms for handling federal funds as for state funds. Contracts for all but the statewide initiatives are developed at the Area Offices.

Table III lists the SFY'04 level of direct care services supported by the FFY'02-04 block grant. Each Area receiving block grant funds, under the direction of an Area Director, is responsible for determining the level and types of services to be supported. Each Area plans and develops a service system most appropriate and responsive to the needs of the Area's clients.

Table IV indicates the amount of block grant funds spent on direct care services by each Area and by the Central Office for statewide initiatives.

Sections 1916(b) and 1913 (a) include "set-aside" provisions that specify targets for administrative expenses and children's services. Briefly summarized, these requirements are as follows:

- Not more than 5% of block grant funds will be used for administration.
- At least 20% of block grant funds will be used for children's services.

Inspection of Table III indicates that the Department is currently in compliance with the first requirement listed above. Of the total block grant, *3.25*% was used to support administration. The Department also complies with the second requirement. Table III indicates that *31.17*% of the grant was used to support contracted services for children and adolescents.

TABLE III

State FY'04 Expenditures Related to FFY'02/04 Grant Award

Program Code	Description	SFY 04 %	Actual Expenditures State FY04
3001	Executive	0.08%	$6,900
3006	Office Administration	1.14%	$98,764
3007	Program Support	2.03%	$175,084
	Sub-Total Administration	3.25%	$280,748
3015	Client and Community Empowerment	5.90%	$509,750
3034	Community Support Clubhouse	6.36%	$548,986
3036	Services for Education and Employment	7.72%	$666,976
3037	Day Rehabilitation	0.27%	$23,209
3039	Homeless Support Services	0.34%	$29,698
3048	Respite Services	9.35%	$807,011
3049	Adult Residential	18.43%	$1,591,138
3050	Outpatient Services	0.14%	$11,985
3056	Individual Support	0.32%	$27,413
3059	Community Rehabilitative Support	12.31%	$1,062,680
	Sub-Total Adult M.H. Services	61.13%	$5,278,846
3065	Comm & School Therap Support	14.50%	$1,252,448
3066	Flex Individual Support Non Res.	14.24%	$1,229,544
3068	Child/Adolescent Day Services	0.53%	$45,423
3075	Flexible Support, Residential	1.54%	$132,649
3078	Child/Adolescent Respite Services	0.37%	$31,663
	Sub-Total Children's Services	31.17%	$2,691,727
3020	Comprehensive Staff Training	0.94%	$81,081
3022	Multi-Discip. Training	0.41%	$35,292
3023	Research	1.66%	$143,292
3027	Adult Forensic Court Services	1.29%	$111,512
3132	Comprehensive Psychiatric Services	0.14%	$12,500
	Sub-Total Mixed Services	4.44%	$383,677
	Total Services	100.00%	$8,634,998

TABLE IV
FFY'02/04 BLOCK GRANT FUNDS SPENDING REPORT
BY AREA

WESTERN MASS AREA
Elizabeth Sullivan, Area Director
P.O. Box 389
Northampton, MA 01061
(413) 587-6295 Total FFY02/04 Spending: $ 480,254

CENTRAL MASS AREA
Elaine Hill, Area Director
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604
(508) 368-3577 Total FFY02/04 Spending: $ 1,505,898

NORTHEAST AREA
Marcia Fowler, Area Director
P.O. Box 387
Tewksbury, MA 01876
(978) 863-5079 Total FFY02/04 Spending: $ 1,459,901

METRO BOSTON AREA
Clifford Robinson, Area Director
20 Vining Street
Boston, MA 02115
(617) 626-9210 Total FFY02/04 Spending: $ 897,562

TABLE IV
(continued)

METRO SUBURBAN AREA Theodore Kirousis, Area Director Westboro State Hospital Lyman Street Westboro, MA 01581 (508) 616-3500	Total FFY02/04 Spending:	$ 1,868,544
SOUTHEASTERN AREA Ron Dailey, Acting Area Director Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402 (508) 897-2020	Total FFY02/04 Spending:	$ 1,373,092
STATEWIDE INITIATIVES Ann Detrick, Ph.D. Central Office 25 Staniford Street Boston, MA 02114 (617) 626-8071	Total FFY02/04 Spending:	$ 1,049,748
TOTAL:		**$ 8,634,998**

CRITERION V - ADULT PERFORMANCE INDICATOR TABLE

Management Systems

2004 Implementation Report

Population: Adults with serious mental illness

Performance Measures:	**SFY'02 Actual**	**SFY'03 Actual**	**SFY'04 Goal**	**SFY'04 Actual**
V/1. *Fiscal resources*				
Value: % of total direct services budget expended for adult community services	**55%**	**58%**	**58.3%**	**59.7%**
Denominator:	**$594.8 m**	**$582 m**	**$557.8 m**	**$573.8**
V/2/1. *Diversity Initiative*				
Value: The Governor's Diversity Initiative is implemented	**N/A**	**1% increase in mid & high level management positions; employment opportunities were created for people with disabilities; staff was surveyed to determine foreign language capabilities**	**Diversity training was provided to all employees; steps were taken to ameliorate the impact of involuntary reductions on diversity of workforce**	**Transitional employment program is maintained; retention programs are strengthened**
V/2/2. *Cultural Competency*				
Value: The DMH Cultural Competence Action Plan is implemented	**N/A**	**CCAP goals for SFY'02 were accomplished**	**CCAP goals for SFY'03 were accomplished**	**CCAP goals for SFY'04 were accomplished**

CRITERION V - C/A PERFORMANCE INDICATOR TABLE
Management Systems

2004 Implementation Report

Population: Children with serious emotional disturbance

Performance Measures:	SFY'02 Actual	SFY'03 Actual	SFY'04 Goal	SFY'04 Actual
V/1. *Fiscal resources for community services*				
Value: % of total direct services budget expended for C/A community services	**12.42%**	**12.67%***	**11.66%**	**13.12%**
Denominator: direct services budget	**$594.8 m**	**$582 m**	**$557.8 m**	**$573.8 m**
V/2/1. *Diversity Initiative*				
Value: The Governor's Diversity Initiative is implemented	**N/A**	**1% increase in mid & high level management positions; employment opportunities were created for people with disabilities; staff was surveyed to determine foreign language capabilities**	**Diversity training was provided to all employees; steps were taken to ameliorate the impact of involuntary reductions on diversity of workforce**	**Transitional employment program is maintained; retention programs are strengthened**
V/2/2. *Cultural Competency*				
Value: The DMH Cultural Competence Action Plan is implemented	**N/A**	**CCAP goals for SFY'02 were accomplished**	**CCAP goals for SFY'03 were accomplished**	**CCAP goals for SFY'04 were accomplished**

APPENDIX

STATE MENTAL HEALTH PLANNING COUNCIL LETTER